THE CHALLENGES OF COMBINING EVIDENCE-BASED BEHAVIORAL HEALTHCARE AND OUTCOME-BASED CLINICAL PASTORAL EDUCATION

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ABSTRACT

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Western medicine in general and behavioral healthcare in particular has changed dramatically over the past fifty years. The powerful economic forces of managed care, medical technology and pharmacology, as well as the emergence of the preventive and alternative care movements have transformed the way physicians and other healthcare providers are trained and practice medicine. The most recognizable feature of this change has been the widespread acceptance of evidence-based medicine.

Western education has also seen paradigmatic changes during this same period. As the educational needs of the American workforce shifted from agriculture to manufacturing to information systems, schools and non-formal educational organizations have struggled to remain current. The most recognizable feature of this change has been the widespread acceptance of outcome-based education, sometimes called "teaching to the test."

As an educational methodology, clinical pastoral education (CPE) has not been immune from both of these influences. Begun in 1925, CPE is experiential adult education for ministry. The Association of Clinical Pastoral Education (ACPE), which

accredits CPE centers and certifies CPE supervisors, has been recognized as a certifying educational organization by the United States Department of Education and has recently shifted CPE's methodology to outcome-based objectives. Like the parallel shifts in medicine and education, this shift in CPE has not been a smooth one for ACPE and its supervisors. This is especially true for the many ACPE supervisors who were trained in a different educational model - one which often focused on resistance to learning and the supervisory interventions thought necessary to lessen that resistance.

This demonstration project explores the history, social context, theories, theology, and justice issues inherent in shifting from a pathology-based model of behavioral medicine and pastoral education to an evidence-based model of behavioral healthcare and outcome-based model of pastoral education at a comprehensive behavioral healthcare facility in Southeastern Pennsylvania and its accredited ACPE program.

DEDICATION

This project is dedicated to Mary Tanney, my life partner, who encouraged, challenged, and loved me through a number of life's challenges, both personal and professional.

ACKNOWLEDGEMENTS

Additionally, there are many other people I want to acknowledge and thank. These are the people who accompanied and nurtured me during these past two busy years. They include Charles Hoeflich, whose tenacious encouragement and financial support first made this project a possibility; members of my D. Min. Site Team: the Rev. Dr. Deborah Rahn-Clemens, Marianne Gilson, John Goshow, Dr. Karen Rosenberger, and Dr. Robert Rapkin, for their practical support and helpful oversight; Karen Kern, for her good humor and incisive commentary; the Rev. Dr. Martha Jacobs, my New York Theological Seminary D. Min. advisor, for her faithfulness to our D. Min. CPE supervisory class and her particular attention to my demonstration project; and all my CPE students who taught me to be a pastoral educator.

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GLOSSARY OF ABBREVIATIONS

ACPE	Association of Clinical Pastoral Education, Inc.
CPE	Clinical pastoral education
EBM	Evidence-based education
EBH	Evidence-based behavioral healthcare
NAMI	National Alliance on Mental Illness
NEC	National Empowerment Center
OBE	Outcome-based education
PSCC	Pastoral Services Consultation Committee

INTRODUCTION

THE CONTINUING DEVELOPMENT OF EVIDENCE-BASED BEHAVIORAL HEALTHCARE AND OUTCOME-BASED CLINICAL PASTORAL EDUCATION

I am a chaplain at a large Mennonite behavioral healthcare facility near Philadelphia, Pennsylvania. I balance my direct care of the patients in this place with the pastoral supervision of seminarians, chaplains, and others who come to Penn Foundation for ministerial training. "Pastoral supervision is a method of doing and reflecting on ministry in which a supervisor (teacher) and one or more supervisees (learners) covenant together to reflect critically on their ministry as a way of growing in self-awareness, ministering competence, theological understanding, and Christian commitment."[1] It is from this educational experience that my demonstration project first emerged. Although this project is location specific and limited in scope and time, I offer it to my supervisory colleagues as an attempt to formulate important questions about the effectiveness of our educational ministry. To paraphrase a recent call for chaplains to engage in pastoral research, I undertook this research for four reasons:

1. To examine my own supervisory methodology, with an eye on its effectiveness;
2. To claim peership within a multidisciplinary team of practitioners, educators, and researchers;

[1] Kenneth Pohly, *Transforming the Rough Places: The Ministry of Supervision*, 2nd ed. (Franklin, Tennessee: Providence House Publishers, 2001), 107-8.

3. To revisit the theological foundations of my educational ministry;
4. To experience the satisfaction that comes from being a participant observer in one's own teaching and learning.[2]

As with pastoral education, the healthcare delivery system in the United States, including and especially the delivery of behavioral healthcare, has undergone profound institutional changes during the past fifty years.[3] Behavioral healthcare refers to that branch of medicine which attends to the interaction of behavior with biology and the environment.[4] Institutional changes in the delivery of behavioral healthcare services can be summarized in the now-familiar phrase "managed care." However, the term "managed care" does not tell the whole story of these changes. The forces generating recent change in the delivery of behavioral healthcare are multiple and complicated. They include huge financial incentives for the medical technology and pharmaceutical industries, reduced government support for public health, the deinstitutionalization of people with mental illness, the re-institutionalization of people with mental illness in our prison system, the recent grassroots movement for patient autonomy, increased litigation, the discovery of more effective psychotropic medications, and the escalating costs of private medicine.

As with healthcare, adult education has also changed dramatically over the past fifty years. The movement away from teaching adults as grown children, from pedagogy to andragogy, as well as the movement of viewing adult education as awareness and

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[2] Paul Bay and Stephen S. Ivy, "Chaplaincy Research: A Case Study," *The Journal of Pastoral Care and Counseling* 60 (winter 2006): 343-52.

[3] See especially W.R. Scott, M. Ruef, P. Mendel, and C. A. Caroneer, *Institutional Change and Organizational Transformation of the Healthcare Field* (Chicago: University of Chicago Press, 2000).

[4] From the Mission Statement of The Society of Behavioral Medicine at http://www.sbm.org. (accessed 6 September, 2006).

liberation, has radically transformed how we currently understand and design adult education programs. Malcolm Knowles and Patricia Cranton are pioneers in the former field and Paulo Freire and bell hooks are pioneers in the latter.[5] Adult education now implies a radically liberating experience that grounds the assimilation of new experience into one's life. Likewise, the acquisition of new knowledge and skills are now viewed as ways to satisfy adult needs for critical self-reflection and transformation. In this new adult educational model, engaged pedagogy and relevant outcomes become the norm, not the exception.

The clinical pastoral education (CPE) movement in America has been profoundly informed by these new adult educational movements of liberation and awareness. With roots in the 1920's, the Association of Clinical Pastoral Education (ACPE) prides itself as a pioneer in the field of experiential adult education for ministry. Early educational emphases included self awareness, acquisition of new skills, clinical learning, and research. For forty years CPE was taught at various medical facilities and in various formats without the benefit of organizational accountability or peer consultation. Two separate organizations on the East Coast and a small number of denominations that trained pastoral educators, however, did hold their pastoral educators accountable to some organizational and denominational standards. It was from these roots that ACPE was incorporated in 1967.

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[5] See especially Malcolm Knowles' *The Modern Practice of Adult Education; from Pedagogy to Andragogy* (Chicago: Follett Publishing Company, 1980); Patricia Cranton's *Professional Development as Transformative Learning: New Perspectives for Teachers of Adults* (San Francisco: Jossey-Bass, 1996); Paulo Freire's *Pedagogy of the Oppressed* (New York: Continuum, 1982); and bell hooks' *Teaching to Transgress* (New York: Routeledge Press, 1994).

Within two years of incorporation ACPE was recognized by the United States Department of Education as a professional accrediting body. In 2002 ACPE added a section for "Outcomes" to its section on "Objectives." This 2002 change in ACPE Standards was done in compliance with U.S. Department of Education's Standards. However, the educational foundation underneath this change, outcome-based education (OBE), was not universally embraced by ACPE supervisors who administer and supervise ACPE accredited programs. The challenges inherent in this change of Standards continue to be debated in ACPE.

It is still too early to assess the effectiveness of OBE by the ACPE. Nevertheless, I began this demonstration project curious about its challenges and potential. My inductive analysis is based on empirical data gained in the field of pastoral supervision. My primary research instrument was an intentional and empirically documented shift in my own supervisory theory and methodology. My research was applied to both the patients I served and the CPE students I supervised.

CHALLENGE STATEMENT

Until recently, diagnosing and treating a patient's mental illness has been a hallmark of Western behavioral healthcare. Similarly, identifying and lessening a student's resistance to learning has been a hallmark of CPE supervision. This demonstration project explored the paradigmatic shifts and tensions in moving from pathology-based medicine and education to outcome-based medicine and education at a comprehensive behavioral healthcare facility and its CPE program.

CHAPTER 1

THE SETTING

THE GENERAL SETTING

Western medicine in general and behavioral healthcare in particular has changed dramatically over the past fifty years. The powerful economic influences of managed care, medical technology and pharmacology, as well as the emergence of the preventive and alternative care movements have transformed the way physicians and other healthcare providers are trained and practice medicine. The most recognizable feature of this change has been the widespread acceptance of evidence-based medicine.

Western education has also seen paradigmatic changes during this same period. As the educational needs of the American workforce shifted from agriculture to manufacturing to information systems, schools and non-formal educational organizations have struggled to stay current. The most recognizable feature of this change has been the widespread acceptance of outcome-based education, sometimes called "teaching to the test."[6]

As an educational methodology, clinical pastoral education (CPE) has not been immune from both of these influences. Begun in 1925, CPE is experiential adult

[6] For more information on this educational movement, see "Teaching to the Test" by Kevin Bushweller, senior ed., *The American School Board Journal* 184 (September, 1997): 20-5.

education for ministry. The Association of Clinical Pastoral Education (ACPE), which accredits CPE centers and certifies CPE supervisors, defines CPE this way:

> "CPE is theological education that takes place not exclusively in academic classrooms, but also in clinical settings where ministry is being practiced. The textbooks for CPE include in-depth study of "the living human documents." By "living human documents," we mean both the people who receive care as well as a study of ourselves, the givers of care. Through the practice of ministry and the reflection thereon with supervisor and peers, the experiential learning that is CPE takes place."[7]

Since most CPE today takes place in medical institutions and since ACPE has been recognized as an accrediting and certifying educational organization by the United States Department of Education, it not surprising that CPE's methodology has also shifted to outcome-based objectives.[8] However, like the parallel medicine and education, this shift in CPE has not been a smooth one for ACPE or its supervisors. This is especially true for the many ACPE supervisors who were trained in a different educational model - one which often focused on resistance to learning and the supervisory interventions deemed necessary to lessen that resistance.

This demonstration project explored the history, social context, theories, theology, and justice issues inherent in shifting from a pathology-based model of behavioral medicine and pastoral education to an evidence-based model of behavioral healthcare and outcome-based model of pastoral education at a comprehensive behavioral healthcare facility in Southeastern Pennsylvania and its accredited ACPE program.

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[7] ACPE [online], cited August 28, 2006, available at http://www.acpe.edu. (accessed 7 September, 2006).

[8] See ACPE [online], available at //http://www.acpe.edu/acroread/2005_standards_manual.pdf, 309-312. (accessed 7 September, 2006)

THE SPECIFIC SETTING: PENN FOUNDATION

Founded in 1955, Penn Foundation is a private, non-profit corporation dedicated to creating and providing comprehensive behavioral health services for residents of Southeastern Pennsylvania. Born of community need, Penn Foundation brings together the finest aspects of the mental health profession with the caring values and qualities of the Mennonite faith tradition.

Penn Foundation offers a full range of mental health and chemical dependency services including: outpatient counseling, pastoral counseling, inpatient treatment (at nearby Grandview Hospital), two adult partial hospitalization programs, an adolescent partial hospitalization program with special education ("Penn School"), children and adolescent community-based intervention services (Wraparound), comprehensive autism services, mental health case management, early intervention services, mental retardation case management, a psychosocial rehabilitation program ("Wellspring Clubhouse"), a community residential services program (apartment dwelling), an inpatient center for detoxification and rehabilitation, adult and adolescent outpatient rehabilitation program, intensive outpatient and non-medical detoxification services, a full range of geriatric services, and two dual diagnosis residences on campus.[9]

FOCUS SITUATION: EXTENDED CPE PROGRAM AT PENN FOUNDATION

Penn Foundation's extended CPE program is a fully-accredited ACPE program. One of two CPE programs at Penn Foundation, the Extended CPE Program is a part-time 12-hour per week educational program based on the ACPE Objectives for Level 1 and

[9] Information about Penn Foundation is available at http://www.pennfoundation.org. (accessed 9 February, 2007).

Level 2 CPE. Level 1 CPE is an educational program in which the student focuses on meeting the Outcomes established in ACPE Standard 311.[10] Level 2 CPE is an educational program in which the student focuses on meeting the outcomes established in ACPE Standard 312.[11] Group educational work is conducted for four hours during a designated evening. This work includes a Bible study, didactic presentation (or book study), a clinical reflection seminar (verbatim), and personal/pastoral identity seminar (small group process). Students also meet with their CPE supervisor for one hour of individual supervision every other week, reviewing clinical material and a reflection paper on their learning. CPE students minister for eight hours per week at a variety of community healthcare settings, including retirement communities, an adolescent psychiatric hospital, hospice, a community hospital, and various social service agencies. These community healthcare sites are affiliated with Penn Foundation's CPE program through annual affiliation agreements. All community sites have a behavioral healthcare component in their delivery of care.

[10] See appendix A.

[11] See appendix B.

CHAPTER 2

HISTORICAL BACKGROUND

The United States has a long history of pioneering research and delivery of services in both modern medicine and higher education. People from other countries come to America for medical training and higher education, while many of our medical and educational advances are exported abroad. However, there have been two significant national shifts in healthcare and adult education in the past generation. They are the movement toward evidence-based medicine (EBM) and outcome-based education (OBE).

Clinical pastoral education (CPE), which is adult experiential education for ministry, is often supervised in medical settings. Therefore, CPE has been influenced by these larger changes in medicine and education. As a CPE supervisor in a large a large behavioral healthcare facility where both national shifts meet, I experience the challenges of both disciplines. This section will explore the origins of these shifts in medicine and education.

The term "evidence-based medicine" was first used in 1992 by Gordon Guyatt in an article in the *Journal of the American Medical Association* and later popularized by clinical epidemiologists at McMaster University Medical School in Canada in 1995.[12] However, the *practice* of EBM actually began in France in the 19th Century with the

[12] Gordon J. Guyatt, D. Cairns, A. Churchill, *et al.* "Evidence-based medicine: A new approach for the teaching and practice of medicine." *Journal of the American Medical Association* 268 (1992): 2420.

research of the physician Pierre Charles Alexandre Louis.[13] Louis' revolutionary work, which included thorough physical examinations and carefully recorded observations and treatment, soon caught the attention of the international medical community and quickly spread to America. This was not surprising, since Paris was the chosen place for American physicians to study medicine in the 19th Century. Starting only with patient data, Louis' guiding motto was "Ars medica tota in observationibus" (The art of medicine is totally in observation)."[14] His carefully documented data was published and soon convinced the medical community of Europe, for example, that the common practice of bloodletting was scientifically ineffective and actually harmful to the patient. Louis' radically new evidence-based methodology was finally published in English in 1936 and quickly caught the attention of a number of prominent American physicians, including Oliver Wendell Holmes. The publication of his work in English quickly spread to American medical schools. Professors called Louis' approach to medical treatment "numerical medicine," since he carefully measured and weighed his observations.[15] As medicine became more scientific than academic, the teaching and practice of EBM became the norm in American medical schools and hospitals. The two words often associated with this shift to scientific medicine were effectiveness and efficiency. In technical language, EMB "is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence based medicine means integrating individual clinical expertise with the best

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[13] P. K. Rangachari, "Evidence-based medicine: Old French wine with a new Canadian label." *Journal of the Royal Society of Medicine* 90 (May 1997): 280.

[14] Ibid., 280.

[15] Ibid., 282.

available external clinical evidence from systematic research."[16] In the non-technical language of a popular on-line encyclopedia, EBM "categorizes different types of clinical evidence and ranks them according to the strength of their freedom from the various biases that beset medical research."[17]

In behavioral medicine, it is important to note that the current debate over insurance coverage and parity in the treatment of mental illness also shares this same history. Parity means that insurance companies and public health monies will be distributed evenly for people suffering from physical *and* mental injuries. Underneath the debate about parity is the long-standing debate between psychiatry and other branches of medicine, a debate reflected in the belief that there needs to be biological or "scientific" evidence for psychiatric illness.

Outcome-based education (OBE) has a different history, although there are some historic parallels. These parallels emerged as the scientific method was applied to the teaching and delivery of education in America. Historically, no one is certain when the term "outcome-based education" first emerged. However, the educational reform movement toward measurable learning outcomes can trace its roots to the1940's with the publication of Ralph W. Tyler's revolutionary book *Basic Principles of Curriculum and Instruction*.[18] Tyler emphasized four fundamental questions that must be considered in any curriculum development. These questions continue to inform curriculum development across the disciplines. They are:

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[16] D. L. Sackett *et al.* "Evidence-based medicine: what it is and what it isn't." *British Medical Journal* 312 (1996): 71-72.

[17] http://en.wikipedia.org/wiki/Evidence_based_medicine. (accessed 11 October, 2006).

[18] Thomas R. Guskey, "Outcome-based education and mastery education: Clarifying the differences." *American Educational Research Association Conference* (New Orleans, 1994), ERIC, ED 368 770: 4.

1. What are the goals of this particular education endeavor?
2. What educational experiences are most likely to accomplish these goals?
3. How can these educational experiences be effectively organized?
4. How can we measure success?

During the past fifty years American educators have challenged the mechanistic and reductionist nature of Tyler's scientific approach to education, but the basic principles of his remain a staple of American educational theory. A number of recent social factors have also contributed to the reemergence of Tyler's original work. Among the social factors are the preparation of students for the workforce of the 21st Century, greater public scrutiny and demand for accountability by failing school districts, globalization and international competition, emergence of the internet with its opportunities for long-distance learning, and the demographic shifts that moved the educational tax base from cities to the suburbs. Navigating these shifts, OBE has come to mean an educational process that does what it says it does with measurable markers.

Clinical pastoral education and the Association of Clinical Pastoral Education (ACPE), which accredits centers and certifies pastoral educators called "supervisors", has its roots in the same history as EBM and OBE . From its beginnings in the 1920's CPE has been an experiential, subject-centered, mastery model of education. CPE has served as a bridge between the academic theories taught in seminaries and the actual practice of ministry in the field. However, it was not until 2002 that ACPE revised their curriculum to include not only objectives, but measurable outcomes. Why did it take so long?

To answer this question adequately, it is important to consider ACPE's history and pioneers. ACPE traces its roots to the mid 1920's with the appointment of Anton

Boisen to Worcester (MA) State Hospital as its first chaplain. Boisen, an ordained Presbyterian minister, is considered by most historians to be the primary pioneer of ACPE.[19] Other pioneers include Richard Cabot and Helen Flanders Dunbar.

Although his appointment to Worcester State Hospital was new, Anton Boisen was not new to Worcester State Hospital. Boisen had earlier been a patient there during two psychotic episodes. It was during one of these hospitalizations that Boisen experienced a vision where he had "broken an opening in the wall which separated medicine and religion."[20] This vision became his life-long vocation, as Boisen's deep respect for unconscious processes and quest to find religious meaning in his suffering challenged academic theological education. Most noteworthy in ACPE's history is Boisen's phrase that people should be read as "living human documents," much the same way as pastors read the Bible. Boisen wrote that "Religious experience can and should be studied before it has gathered dust on library shelves, and the living human documents are the primary sources for the understanding of human nature."[21] I will explore later what Boisen might have meant when he invited his early clinical pastoral education students to read themselves, one another, and those they served as "living human documents."

In 1927 Dr. Richard C. Cabot published an article called "A Plea for a Clinical Year in the Course of Theological Study." Cabot was an influential surgeon at Massachusetts General Hospital and professor at Harvard. He also happened to live

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[19] See especially Glenn H. Asquith's (ed.) *Vision from a Little Known Country* (Decatur, GA: Journal of Pastoral Care Publications, 1992); Alison Stokes' *Ministry after Freud* by Allison Stokes (New York: The Pilgrim Press, 1985); and Charles Gerkin's *The Living Human Document: Re-Visioning Pastoral Care in a Hermeneutical Mode* (Nashville, TN: Abingdon, 1984).

[20] As quoted by Asquith, ed., 6.

[21] Ibid., 77.

across the street from and often visited Episcopal Theological Seminary in Cambridge. Cabot's publication is often regarded as the beginning of the "clinical phase" of CPE.[22] Today we take such training, now called "internships," for granted and forget that Cabot's "Plea" was really something quite radical, at least in academic seminary circles. Based on a medical school internship/residency model, Cabot suggested that seminarians leave their seminaries and, under supervision, apply their theology to people in crisis. He wrote, "When we urge a theological student to get 'clinical experience' outside his lecture rooms and chapel, to visit the sick, the insane, the prisons, and the almshouses, it is not because we want him to get away from theology but because we want him to practice his theology where it is most needed, i.e., in personal contact with individuals in trouble."[23]

Cabot's "plea" echoed the sentiments of a precursor to CPE, Elwood Worcester, founder of the Boston-based Emmanuel Movement. In 1909 Worcester wrote that, "The peculiar art of ministering to the sick cannot be acquired by reading or by listening to didactic lectures," nor can it be acquired by "an empirical hit-or-miss fashion, from mere contact with the sick." It can only be acquired, echoing the French physician Pierre Charles Alexandre Louis, by systematic "scientific instruction."[24] Within four months of Cabot's "Plea", Boisen published a plea of his own called "The Challenge to our

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[22] Stokes, 50.

[23] Richard C. Cabot, *Borderline of Ethics* (New York: Harper and Row, 1926), 22.

[24] Elwood Worcester and Samuel McComb, *The Christian as a Healing Power* (New York: Moffat, Yard and Co., 1909), 35.

Seminaries", where he challenged both physician and minister to view mental illness as an illness of the soul.[25]

Richard Cabot's other significant contribution to CPE was the written case study, a stable of all ACPE accredited programs. Building on the earlier work of the French physician Pierre Charles Alexandre Louis, Cabot believed that medicine is essentially an empirical and inductive science. Careful note-taking and written reflection provided the practitioner an opportunity to test deductive theory with inductive evidence. In collaboration with an early CPE student, Russell Dicks, who wrote down his prayers with patients, this early note-taking later developed into the "verbatim," as pastoral care became an independent discipline and moved from psychiatric to general hospitals.[26] Cabot's contribution to CPE was his interest in pastoral competencies and educational methodology.

The third CPE pioneer was Helen Flanders Dunbar - physician, psychiatrist, and scholar of Dante. As a seminarian at Union Theological Seminary in New York City, Dunbar was an early CPE student of Anton Boisen who invited her to Worcester State Hospital in the summer of 1925. Later, after receiving her Ph.D. and medical education at Yale University and her psychiatrist training in Vienna, Dunbar returned to the United States to pursue her interests in psychosomatic medicine and theology. She quickly became an important force in CPE. In the early 1930's she became the Executive Director of the Council for Clinical Pastoral Training of Theological Students in New

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[25] Stokes, 51.

[26] Donald Capps and Gene Fowler, *The Pastoral Care Case: Learning about Care in Congregations* (St. Louis: Chalice Press, 2001), 13.

York City. Dunbar's contributions to CPE were her view of medicine as holistic and her plea for more research in the area of pastoral care.

Personality conflicts and philosophical differences eventually led to divisions in both the Boston and New York City CPE centers. As well, another major psychotic episode so debilitated Anton Boisen that he no longer contributed to the development of the clinical pastoral education movement as it moved from personalities to organizations.

By 1935 there were two distinct CPE organizations, one led by Cabot in Boston and the other by Dunbar in New York City. At the risk of oversimplifying rather complex identities, Cabot's group emphasized the acquisition of pastoral skills, while Dunbar's group emphasized self awareness and pastoral research. These two groups were called The Institute for Pastoral Care in Boston and The Council for Clinical Training in New York. As separate associations, they continued independently until 1967 when they merged to form the Association for Clinical Pastoral Education. But they were not alone in this merger. To this new incorporation was joined two other pastoral care training programs from two very different churches - The Lutheran Church of America and the Southern Baptist Association.

ACPE first affiliated with the U. S. Department on Education soon after its 1967 incorporation - in 1969. Although implied in the Objectives of CPE, the word "Outcomes" only entered the ACPE Standards in 2002. This was done, according to ACPE correspondence, "to be in compliance with the U.S. Department of Education Standards."[27] However, as John Gleason notes in a recent guest editorial in *The Journal of Pastoral Care and Counseling* titled "Evidence-Based Standards of Care in Pastoral

[27] The Rev. Dr. Teresa E. Snorton, Executive Director, ACPE. "ACPE's relationship with the U.S Department of Education," private Email (accessed 10 August, 2006).

Practice," ACPE's outcomes now imply more than compliance. He states, "Best practices in medicine and the behavioral sciences are most clearly identified with measurable outcomes,….."[28] Here Gleason connects outcomes with best practices and again, by implication, competencies. I believe that Gleason's connection is accurate and accounts for much of the widespread acceptance and resistance to the new ACPE Standards.

At the risk of oversimplifying a complex situation, the acceptance of OBE in ACPE seems to have emerged from the tension of two valid educational movements in CPE's history: Richard Cabot's plea for documented and measurable skill development and Anton Boisen's plea for a deeper integration of our unconscious processes and identity. As with medicine's response to EBM during the last century, ACPE's response to OBE will unfold gradually. Initially, it will unfold in the establishment of measurable outcomes for practitioners; secondly, in the development of new Supervisory, Level 1, and Level 2 CPE curricula; and thirdly, in discussions between ACPE and the Association of Professional Chaplains regarding best practices and demonstrated outcomes for pastoral certification. As mentioned above, what OBE adds to this CPE are two new factors: the demonstrated assessment of one's learning against an external goal (an "outcome") and the development of a setting and curriculum that can facilitate the achievement of that learning.

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[28] John Gleason, "Evidence-Based Standards of Care in Pastoral Practice." *Journal of Pastoral Care and Counseling* 60 (fall, 2006): 198.

CHAPTER 3

CULTURAL ANALYSIS

The educational psychologist Clyde Kluckhorn one wrote that "There is no such thing as a view from no where."[29] We see what we see from where we are. As well, the culture from where we see informs and shapes our vision. "Culture does not float free from institutions. A powerful institutional order will carry a powerful culture."[30] Medicine and education are two such powerful institutions. The former is largely, though not exclusively, regulated by free market forces. The latter is largely, though not exclusively, regulated by the state. At Penn Foundation we experience regulation by both forces.

Behavioral healthcare and clinical pastoral education are cultures embedded within cultures. The larger and more remote "holding cultures" are global economics, information technology, and national political priorities and policies. Although important to keep in mind, a thorough exploration of these more remote cultural forces are beyond the scope of this particular research. However, the more immediate holding cultures are within the scope of this research. They are medicine, ministerial education, and pastoral

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[29] As quoted by Jerome Bruner, *Acts of Meaning* (Cambridge, Massachusetts: Harvard University Press, 1991), 12.

[30] Robert N. Bellah, "Is there a common American culture?" *Journal of the American Academy of Religion* 66 (Autumn 1998): 800.

care. This chapter will explore the roots of these more immediate cross-cultural influences and their effect on those they are mandated to serve.

Although diverse in their historic origins, the cultural pressures that informed and shaped evidence based medicine (EBM), evidence based behavioral healthcare (EBH), outcome based education (OBE), and outcome based clinical pastoral education (CPE) intersect daily in programs like Penn Foundation and other behavioral healthcare programs across this nation where CPE is supervised. This intersection has not always been a smooth one. Behavioral healthcare programs continue to struggle under the weight of shifting government policies and dollars, the demands of the popular patient autonomy movement, and third party insurers that require a more "objective," biomedical evidence-based conception of mental illness. CPE supervisors struggle to adapt to new outcome-base Standards. At Penn Foundation, for example, these external pressures have created a behavioral healthcare culture that looks to the future with mixed emotions – hopeful about recent advances in biochemistry, psychosocial rehabilitation, and deinstitutionalization; discouraged by shrinking government dollars for behavioral healthcare, limited access to care through lack of insurance parity, and the increasing homelessness and imprisonment that accompany many people with severe and persistent mental illness. As a CPE supervisor, I have noticed that many of my colleagues struggle to adopt educational and group theories that adequately inform and shape their educational practice.

Thomas Nys, a psychiatrist and mental health analyst who teaches in Belgium, and Mauritius Nys, a psychiatrist and mental health analyst who teaches in the Netherlands, have written extensively about the cultural pressures on psychiatry today. In

a word, psychiatry is the medical "face" of behavioral healthcare. "The role of the psychiatrist, Nys writes, "is to support the general practitioner in the management of psychiatric illness."[31]

Nys highlights two sources of cultural pressure on psychiatry today: patient autonomy and managed care. While welcoming the waning paternalism inherent in the patient autonomy movement, Nys notes that an excessive adherence to patient autonomy can actually interfere with a psychiatrist's first ethical mandate, beneficence the duty to "do good" and act in the best interests of the patient. Nys notes two cohorts of patients who especially over-stress the healthcare system and interfere with this duty: "the host of needy patients excluded from health care simply because they fail to call for help [e.g., people addicted to drugs or people who use the Emergency Room as their primary care physician]" and "the excessive demands made on the health care system by those who claim help" for services that may or may not help them [e.g., Prozac or any one of a number of medications now advertised in the public media]."[32] Both cohorts come to Penn Foundation. With an ever-increasing scarcity of resources, the problem here, as elsewhere, quickly becomes an ethical and justice issue - who decides what services are delivered and to whom?

Until recently, the clinical pastoral education movement has enjoyed a relatively theory-free existence, at least when it came to education. The cultural pressures of consolidation in 1967 and alignment with the Department of Education in 1969

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[31] Thomas Nys and Mauritius Nys, "Psychiatry under pressure: Reflections on psychiatry's drift towards a reductionist biomedical concept of mental illness," *Medicine, Health Care and Philosophy* 9 (2006): 108.

[32] Ibid., 108.

eventually led to the adoption of educational outcomes in 2002. Lagging behind, however, were coherent educational theories to accompany these cultural pressures. A handful of CPE historians and theorists have explored the history of this cultural dissonance and one in particular has offered practical educational counsel.[33] ACPE Accreditation, Certification, and Standards committees have also sought to hold CPE centers, supervisors and supervisory education students accountable for theory and practice with these changes in the ACPE Standards. The benefits and losses of these cultural pressures are still debated by the ACPE membership.

Clearly, ACPE centers have benefited by the organization's alignment with the Department of Education through the federal loans program available to qualified CPE students, the "Medicare Pass Through" reimbursement program to pastoral care departments, and a clearer immigration status for foreign CPE students. ACPE supervisors and supervisory education students have also benefited by the renewed interest in educational theory, continuing education, and the dissemination of best practices among membership.

Losses, or at least potential losses, in outcome-based CPE have been tallied in a number of areas. In conversations with my supervisory colleagues, they include the dangers of undermining the centrality of the individual student's learning contract and the repositioning of the supervisor as judge, rather than co-investigator and educational colleague; a mistrust of process learning; and the fear of designing curricula that, like their counterparts in higher education, "teach to the outcome," rather than the student.

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[33] See especially Allison Stokes, *Ministry after Freud* (New York: The Pilgrim Press, 1985); Joan Hemenway, *Inside the Circle: A Historical and Practical Inquiry Concerning Process Groups in Clinical Pastoral Education* (Decatur, Georgia: Journal of Pastoral Care Publications, 2000).

As with their colleagues in behavioral healthcare who cannot "prove" that their medical interventions are cost-effective - just that their patients are getting better based on the evidence, CPE supervisors can now say that their students are learning based on evidence measured against outcomes. As CPE outcomes reflect the consensus on best practices in the delivery of pastoral care and as CPE supervisors document their students' learning against these best practices, future CPE supervisors will adjust their theories and practices to reflect these realities.

CHAPTER 4

METHODOLOGICAL RESEARCH AND ANALYSIS

Many CPE learning theories focus on resistance to learning and the suggested supervisory interventions to lessen that resistance. This demonstration project took a different approach and focused on a student's competencies and satisfaction or dissatisfaction with learning. By building on competencies and satisfactions and developing interventions to address dissatisfactions, I hoped to increase the CPE student's capacity for learning.

This research project developed over time. During the summer of 2006 I used a 10-week intensive CPE program as a pilot project to prepare for the actual demonstration project, which began on September 5, 2006. This pilot project explored the benefits of introducing a gift discernment model of education during the first and last week of the program. This model included an invitation for all students to bring to the CPE orientation a gift that best described their perceived gifts for ministry. I asked each of them to explain their choice to his or her peers. During their final Bible study, I asked each student to bring in a gift for each of their CPE peers that best describes their gifts for ministry. On the last day of the summer program, August 11, 2006, I scheduled an exit interview/focus group. This exit interview was facilitated by two members of the Pastoral Services Consultation Committee (PSCC). The purpose of the exit interview was to

review the CPE program as a group. The overall purpose of the pilot project was to test and refine these three research tools: the initial gift, the final gift, and the exit interview.

In consultation with Penn Foundation's Director of Quality Improvement, a member of my site team, I developed an informed consent declaration for all CPE students to sign before beginning CPE and competency rating scales for Level 1 and Level 2 CPE based on the Likert Scale Model for Agreement. The purpose of these competency rating scales was to alert the CPE student to their self-reported strengths and deficits for ministry. All students signed an informed consent form which can be found in appendix C. The competency rating scales can be found in appendix D. After the summer pilot project, I redesigned my research tools in preparation for this demonstration project. The research tools expanded to seven. They included:

1. A process whereby a CPE student would bring a gift to CPE that best described his or her perceived gifts for ministry during CPE orientation and a gift which best describes his or her CPE peers' gifts for ministry during the final week of the program;
2. Paper and pencil surveys (called "competency rating scales") based on the outcomes for Level 1 and Level 2 CPE, administered at the beginning of CPE, after the fifth week of CPE, and after the fifteenth week of CPE;
3. A didactic presentation on gift discernment and competency-based learning which I presented during the first two weeks of CPE;
4. Bi-weekly supervisory process notes focusing on each of my six CPE student's satisfaction and dissatisfactions with learning and the supervisory interventions I

used to address dissatisfactions, as well as brief commentary on the supervisory alliance;

5. A mid-unit staff evaluation for each of my CPE student preceptors based on a gift discernment model of assessment (appendix E);
6. The exit interview/focus group interview administered at the mid-point of CPE (appendix F).
7. Weekly supervisory process notes focusing on our group educational activities and my competency of self-containment.

Because of confidentiality, my supervisory notes have not been included in this demonstration project. They were, however, shared with my Site Team on January 2, 2007 and are summarized below.

By building on satisfactions and developing interventions to address dissatisfactions, I hoped to increase the student's capacity for more positive learning outcomes. Also, when I or my student caught some learning dissatisfaction early in the educational process, an opportunity emerged to strengthen the supervisory alliance by readjusting the student's learning goals and/or my supervisory strategies. It was my theory that this, too, would increase a CPE student's capacity for more positive learning outcomes.

On September 12, 2006, during the CPE orientation, each student brought a gift to their peer group that best described his or her gifts for ministry. This group presentation lasted about two hours. The names and sex of my students have been changed, to respect their anonymity.

Student 1 brought in his drawing of a dandelion to describe his gifts for ministry. He began his presentation by asking the question, "Is the dandelion a weed or a flower?" He then told his CPE peers that he often wondered the same about himself. "But in God's eyes," he said, "we're all flowers. That's what our faith tells us." As he pointed to various parts of the flower, he talked about the parallels between the dandelion's tenacious roots, edible leaves, and movement toward the sun and his own vocational discernment. "My roots in Christ are deep," he told his peers. "Even though a dandelion's leaves look like weeds, they're actually edible and people also make wine from them. So, a lot depends on how you look at it," he said. He finished his presentation by reminding the group that a dandelion always turns toward the sun for growth. In his own discernment of ministerial gifts, he has learned to turn toward the "Son" for insight and nurture.

Student 2 took her guitar out of its case and played a song she wrote a number of years ago. The song she sang was a lively song of praise and thanksgiving for God's companionship in her life. After she finished her song, she talked about her call to ministry and how she responded to that call in various congregational and chaplaincy settings where she ministered primarily in supportive roles. As with the guitar that accompanied her singing, she now sees her ministry as one of accompaniment and support. She used the word "companionship" to describe her CPE ministry with patients on the oncology floor of the local community hospital.

Student 3 took a wire sculpture and various gardening tools out of a canvas bag, as she described shifts in her self-understanding as a minister. The wire sculpture of a person at a lectern was a gift from her husband, she told the group. It was an apt description of how she and others viewed her gifts for ministry when she was a young

minister: teaching and preaching. As a pastor she successfully exercised these gifts in a number of small congregations. Over the years, though, she came to realize that ministry is more than teaching and preaching. Counseling a number of individuals, couples, and families, she began to accept her other gifts for ministry, especially nurture and guidance. During an intense CPE unit a number of years ago, oncology patients at a large urban hospital helped her confirm her gifts for nurture. As she carefully took out two gardening tools from her canvas bag and rubbed them together, she described to her peers her gifts for ministry as "cultivation" of people's souls.

Student 4 set a Coleman camp lamp and a brown paper bag on the table. He then talked about his call to ministry. This journey included debilitating fears and doubts. These fears and doubts eventually caused him to leave active ministry for over 20 years. He returned to active ministry only last year, after two years of vocational discernment with his church officials and others. During his gift discernment presentation, He read from Luke 8: 16-7:

> Nobody lights a lamp and then covers it with a basin or puts it under the bed. On the contrary, he puts it on a lamp-stand so that those who come in may see the light. For there is nothing hidden that will not become public, nothing under cover that will not be made known and brought into the open.[34]

Student 5 was currently discerning her gifts for chaplaincy ministry. She talked about the medal that she wears every day. The medal is actually a silver coin which has been pounded flat, something she can "relate to," she told her peers. On the coin has been pressed the image of a tree, which she sees as an important symbol of her gifts for ministry. She especially likes this tree because it is an evergreen, which happens to be the

[34] All Biblical references are from *The New English Bible with the Apocrypha* (Oxford: Oxford University Press, 1970).

same name as her street. "Trees are strong and have deep roots", she told her peers. Over the years she has gathered regularly with a prayer group of kindred spirits who live on Evergreen Street. A Quaker friend introduced her to his meeting's "Clearness Committee," which recently helped her discern her gifts for ministry and call to hospital chaplaincy.

Student 6 was ordained by his denomination last year. On the day of his ordination his wife surprised him with the gift of a wall hanging that now adorns his office. The wall hanging, which is handmade, quotes the prophet Isaiah (58: 10-12), which he read slowly to the peer group.

> If you feed the hungry from your own plenty,
> and satisfy the needs of the wretched,
> then your light will rise like dawn out of darkness
> and your dusk will be like noonday;
> the Lord will be your guide continually
> and will satisfy your needs in the shimmering heat;
> he will give you strength of limb;
> you will be like a watered garden,
> like a spring whose waters never fail.
> The ancient ruins will be restored by your own kindred
> and you will build once more on ancestral foundations;
> you shall be called Rebuilder of broken walls,
> Restorer of houses in ruin.

After he read these words, he went on to describe his ministry as a social worker and chaplain with people struggling with mental illness and developmental disabilities. Picking up the words of Isaiah, he described many of these people as poor, marginalized, forgotten, yet hungry for spiritual food. He was grateful for his wife's insight into his gifts for ministry, as they were reflected in Isaiah's words "Rebuilder and "Restorer."

At the end of the presentations, everyone expressed satisfaction with the exercise.

A number of the CPE students named additional learning that became available to them during their presentation.

Two paper and pencil surveys, called "Competency Rating Scales," were administered to all students before CPE, during their orientation as a pre-test on September 5, 2006, after five weeks of CPE on October 10, 2006, and again after fifteen weeks of CPE on December 19, 2006. Graphs for each of the six students can be found in appendix H. An aggregate graph for all students can be found in appendix I.

On September 12, 2006 I taught my didactic presentation on gift discernment. This took about 45 minutes. A Power Point presentation of the didactic can be found in appendix L. The didactic began with the question: "What competencies do you believe are important for a ministerial identity and a basic level of pastoral functioning?" I used newsprint to record these competencies. The CPE students named the following competencies:

- Reflective listening skills
- Assessment skills
- Healthy boundaries
- Awareness of one's strengths and weaknesses
- Love of ministry
- The capacity to receive constructive criticism

After discussing each of these competencies, I asked my CPE students to name their impressions and understanding of clinical pastoral education. Again, I used newsprint to record their impressions and understanding. The students mentioned the following:

- ❖ Rigorous supervision
- ❖ Honest feedback from peers
- ❖ Anticipated helplessness in the face of new experience
- ❖ A change of pastoral identity and functioning
- ❖ Personal healing
- ❖ Intimacy
- ❖ Strict confidentiality

After discussing these impressions and understandings, I asked the three members of the CPE group who had a previous experience of CPE to talk about their past learning experience in light of their present learning experience. This they did readily, although one of my students later told me in individual supervision that she did not appreciate this part of the didactic. Her dissatisfaction emerged from the fact that she did not see this program as an extension of her previous CPE, but rather a "new beginning" with new peers and a new program.

I continued the didactic by reminding my students that CPE tries to balance stimulation for one's learning with time and reflective tools to learn from that experience. "If you tell me, I'll probably forget it. If you show me, I'll probably remember it. If you involve me, I'll learn from it", I said. I also shared with them my own definition of education as the assimilation of new experience into one's life. As an educational methodology, CPE is "double-loop learning. In this kind of learning," I said, "whatever answer you come up with always leads to more questions."

Next I outlined a brief historical overview of CPE. Historical players included Richard Cabot, Anton Boisen, and Helen Flanders Dunbar. My sources were Glenn

Asquith's *Vision from a Little Known Country: A Boisen Reader*, Charles Powell's, *Head and Heart: The Story of Clinical Pastoral Education*, Robert Powell's *Fifty Years of Learning Through Supervised Encounter with Living Human Documents*, and Allison Stokes' *Ministry after Freud.*

I then focused on ACPE and the association's definition of ministerial competencies (called Level 1 and Level 2 "objectives" and "outcomes"). After passing out a copy of the objectives and outcomes to each student, we discussed each one. I then wrote down their understandings of the term "gift discernment" and we discussed these. I finished the didactic with two Biblical passages that refer to ministerial gifts and gift discernment and my own shift in supervisory methodology from resistance to learning to gift discernment. The Biblical passages I selected were:

- 2 Timothy 2: 7 ("Mark well what I am saying: the Lord will give you discernment in all things.")
- 1 Corinthians 12, 13, and 14 ("There are varieties of gifts, but the same Spirit. It is the spirit who bestows these gifts. Love is the greatest spiritual gift. Be zealous about your gifts.")

We briefly discussed the meaning of these passages in our lives. Feedback on the didactic was positive. One CPE student told me later that it took the "mystique" out of CPE – something he very much appreciated.

Throughout the program all five CPE students voiced satisfactions and dissatisfactions regarding their CPE learning. These satisfactions and dissatisfactions were noted in my bi-weekly individual supervisory process notes. Initially, I planned to write these supervisory process notes weekly, but the Extended CPE program only calls

for bi-weekly supervision. These notes were summarized and reviewed by my Site Team during January 2007. They are not included in this demonstration project, thus guaranteeing student anonymity. However, below are my CPE student satisfactions and dissatisfactions regarding their CPE learning and my supervisory interventions. As I discussed earlier, expressed satisfaction or dissatisfaction with learning is a necessary condition of adult learning. Perhaps more importantly, this phenomenon is also true in ministry. In my experience with our pastoral counseling clients at Penn Foundation, those who are satisfied with their counselor, tend to work harder at their goals.[35] As above, the names and sex below have been changed, to respect student anonymity.

- Student 1 was satisfied with the quality of peer and supervisory feedback from her clinical case studies and dissatisfied with the feedback she received in her small group process. She felt her group was stuck in a comfort zone and too supportive of one another. She felt they needed to move to a more direct and even confrontational position with one another's learning. With this feedback, I encouraged her to raise the issue with her peers during small group process.
- Student 2 was satisfied with the overall quality of her peer group learning, although dissatisfied with the criticism of one peer. With this feedback, I encouraged her to continue building on the trust and cohesion she experienced in the peer group and to speak to her peer in group about how he experiences her.
- Student 3 was satisfied with the quality of our supervisory relationship and dissatisfied with the fact that he was behind in writing his clinical case studies. With this feedback, we explored what it was about our relationship that worked

[35] For a study of this pastoral phenomenon, see Nabukazu Tanaka, "Spiritual Dimensions as Factors of Client Satisfaction with Pastoral Counseling" (M.A. diss., Garrett-Evangelical Theological Seminary, 1991).

for him and I encouraged him to set aside some intentional time to get three of his case studies done by Christmas.

- Student 4 was very satisfied with the quality of individual supervision and somewhat dissatisfied with his relationship with his on-site preceptor. He wished he had more intentional time with his preceptor. With this feedback, I continued to build on what was working in supervision and I spoke to his preceptor about their relationship, encouraging my student to claim more time with her preceptor.
- Student 5 was satisfied with the quality of her relationships in the CPE program: her peers, her preceptor and the residents at her clinical site, and her supervisor. Although she did not name it as dissatisfaction, she was able to articulate the difficulty she had in praying out loud for her peers during our Bible Study. I encouraged her to speak to her peers about this during our small group process.
- Student 6 was satisfied with the quality of the didactic presentations and dissatisfied with the time-keeping in the group. With his feedback, I encouraged him to explore his valence toward didactic learning and voice his concerns with his peer group about time boundaries.

Mid-unit staff evaluations on my students were very positive. Each student asked two clinicians to do their evaluation. I shared these staff evaluations with my students during individual supervision. My students received these evaluations with great satisfaction.

The Exit Interview, normally conducted at the end of the program, was administered on December 19, 2006. The interviewer was Penn Foundation's President and CEO, John Goshow, who also serves as a member of the Pastoral Services

Consultation Committee and my D. Min. Site Team. The outline for this group interview is found in appendix F and the full report is found in appendix G. Overall, the students voiced great appreciation and learning from their CPE program.

After December 20, 2006 I began to use my various research tools to determine whether my change in supervisory methodology actually helped my CPE students learn. I approached two members of my Site Team to help graph student and group progress, as this progress was reflected in the Competency Rating Scales.

In early January 2007 I sent a rough draft of my demonstration project to my D. Min. Site Team for their review. In early February 2007 I sent a finished draft of my demonstration project to my D. Min. Site Team for their approval.

CHAPTER 5

THEOLOGICAL ANALYSIS

> Religious experience can and should be studied before it has gathered dust on library shelves, and the living human documents are the primary sources for the understanding of human nature. (Anton Boisen)[36]

I believe that Boisen had it right. The most obvious place to begin one's theological exploration is the religious experience of one's own life and the lives of those we serve. But more importantly to me than what seems obvious is my conviction that divine revelation happens primarily in and through our shared and common humanity. Two Biblical stories provide a metaphorical framework for this belief. They are the narratives of creation and incarnation. These two narratives, especially as they are told in the Book of Genesis and the Gospel of John, continue to function as essential stories in my continuing theological and ministerial development.

Five hermeneutical theses emerge from my ministry with people struggling with mental illness and addiction. These five theses attempt to engage those I minister to in the conversation we call theology. The language of the first four theses reflects the philosophical vocabulary of Michael Polanyi, while the fifth thesis reflects the vocabulary of theological orthopraxis.

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[36] Asquith, ed., 77.

1. Theology is an intentional attentiveness to ourselves, others, our world, and our future. The goal of this attentiveness is new awareness. Awareness means an awareness of where I stand and view myself, others, our world, and our future. This attentiveness is not a stage, but a stance and a commitment.
2. Theology is intentional reflection on ourselves, others, our world, and our future in community. We do not know who we are apart from the communities in which we live. As an example of this, reflection on my own mental illness, depression, has drawn me closer to those I serve at Penn Foundation. This reflection is also an opportunity for meaning-making, since Christian theological reflection implies how we matter to God and how we matter to each other.
3. Theology involves decision-making for ourselves, others, our world, and our future in light of our sacred texts, our history, and our personal experience of God. This reflection always involves some change in our behavior, "doing theology." Doing Christian theology means entering into friendship with a transcendent God who took flesh in the person of Jesus Christ. Friendship with this transcendent God is now possible through discipleship with the Holy Spirit. Discipleship means more than learning. It means following, going where Jesus went - dying to self and living for others.
4. Theology means committing ourselves to an active participation with the creative and evolving self-revelation of God. This implies that there are multiple paths to the same God who has many names and that the only authentic language of theology is the vernacular.

5. Authentic theology emerges from the local situation. This means that theology is both orthodoxy and orthopraxis. Authentic theology, to quote Jesus, bears good fruit, not dead branches.

Of these five theses, my primary hermeneutical principle that "Theology is intentional reflection about oneself, others, our world, and our future in community" provides a practical framework for what follows.

Paying attention to one's experience is the first step in theological reflection. This attention can lead to greater self-awareness, which is the goal of all education. I believe that doing theology is something that everyone can do. However, people struggling with brain injuries or debilitating attachments think differently than people without these illnesses because the very organ we use to make sense out of our experience is broken. This does not mean that people with brain injuries or debilitating attachments cannot do theology. They can and they do. It is just that their theology sounds different.

Additionally, three contemporary metaphors provide the architecture necessary for this framework. The metaphor of Anton Boisen mentioned above, people as "living human documents" and the two metaphors of Michael Polanyi, educational awareness as "indwelling" and "personal knowledge," emerge throughout my theological reflection. The systematic theology of Karl Rahner, especially his writings on grace and meaning, also informs the theology underneath this demonstration project.

Anton Boisen, one of the three founders of the clinical pastoral education movement, believed strongly that God speaks to us not only through our sacred scriptures, but most especially through our experience of self and others. Pastoral care, in Boisen's view, is the art of *reading* self and others as if self and others were sacred texts.

As a CPE supervisor, I believe that a careful reading and understanding of self and others informs how we read and understand our sacred scriptures and how we use them in pastoral care. This, I believe, is a unique form of intertextuality.

Before his death in 1979, Michael Polanyi was a scientist and philosopher who taught at the University of Chicago. Polanyi believed that education was the assimilation of new experience into one's life. This assimilation implies transformation, since Polanyi also believed that the goal of education was greater self-awareness. Polanyi's favorite metaphor for this kind of learning is *indwelling*, which he believed is always *personal*, since education as transformation implies some measure of personal commitment. As supervisory CPE shifts from a primarily intuitive model to one with demonstrated and measurable outcomes and as my CPE supervision shifted from a pathology and resistance-to-learning model of education to one of gift discernment and competency-building, the word *transformation* took on new educational meaning.

In his later years, the German theologian, Karl Rahner, wrote a great deal about transformation, grace, and meaning. Rahner's theology provides this demonstration project with the deep theory underneath Boisen and Polanyi's more operational theory. Having been raised and educated a Catholic, I understand Rahner to mean that the grace that accompanies transformation refers to something more than mere forgiveness of sins. In Rahner's theology, grace means a radical sharing in God's divine nature. This sharing, metaphorically a conversation between God and God's creatures, implies that this same divine conversation continues even today with whom I serve. However, as a chaplain and pastoral educator, this conversation is no longer metaphorical, but a *real* conversation, as chaplain and patient, supervisor and student, struggle to make meaning out of their lives

by voicing concerns and hopes to one another before God. I expand on the pastoral implications of this divine conversation, the unique "intertextuality," in Chapter 6.

Although historians are unclear exactly what Anton Boisen might have meant when he invited his early clinical pastoral education students to read themselves, one another, and those they served as living human documents, historians of the clinical pastoral education movement, including Glenn Asquith, Alison Stokes, and Charles Gerkin, have weighed in with their interpretation. Asquith believes that Boisen meant that "theology was method as well as content, and that the study of 'living human documents' was an indispensable aspect of that method."[37] Stokes believes that Boisen meant that theological students should base their theological reflection on the "authority of experience."[38] Gerkin believes that Boisen meant that seminarians and pastors engage in "a careful and systematic study of the lives of persons struggling with issues of the spiritual life in the concreteness of their relationship."[39] I believe that Boisen intended all three - that theological method and content are inseparable, that theological reflection must begin with experience, and that the relationship between pastoral caregiver and receiver is a valid aspect of theological reflection.

Michael Polanyi's metaphor of learning as *indwelling* and his four stages of learning are particularly helpful in understanding the notion of pastoral intertextuality, as it applies to Boisen's metaphor of living human documents. In Polanyi's theory, education is a personal activity which deliberately attends to our *common need to know* and to the *future possibility* that knowing holds for the individual and the wider

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[37] Ibid., 139.

[38] Stokes, 64.

[39] Asquith, 37.

community. In a very real sense, we *dwell in* the meanings we are able to grasp, as we extend ourselves into that which we find coherent or congenial. This indwelling and extension can be noticed in four developmental stages. How and what we *pay attention* to, how and what we *reflect* upon in light of that attentiveness, what we *decide* to do because of that reflection, and what we *commit* ourselves to consequent to that decision these four stages are practical ways to understand and demonstrate how we read and understand one another.

Both Boisen and Polanyi view awareness as the primary goal of all education. For Boisen, this awareness is mediated through an encounter with self and others, a decision to *read* self and others as *living human documents*, what I call *pastoral intertextuality*. As mentioned above, this awareness of pastoral intertextuality responds well to Polanyi's four stages of development and integration: paying attention, reflection, decision-making, and commitment to the process. What is unique to CPE is that both of these theological and educational theories find an experiential home in praxis learning. If CPE acknowledges that the primary stimulation for learning emerges from the experience of those we serve, and I believe it does, then this experience has the potential for what the educator bell hooks calls "engaged pedagogy"[40] and I call mutual transformation. In that conviction, my demonstration project also explores the conditions or frame of reference that make transformational learning possible.

In conclusion, whether I approach my understanding of the hermeneutics of Anton Boisen or the educational theory of Michael Polanyi or the theology of Karl Rahner, one thing still seems certain: we are fundamentally more than we can ever know

[40] hooks, 20.

about ourselves. In his commentary on the writings of Karl Rahner, the editor Leo O'Donovan writes:

> What we make of our lives is always a kind of compromise or synthesis between available possibilities on the one hand and our own consciousness and freedom on the other. And what we make of our lives is never fully comprehended or completely open to our introspective assessment. We remain unknown even to ourselves, not in this or that part of our lives, but in their ultimate totality, in what the subject of all our experience finally is. To the extent that we do approach the truth of ourselves, it is with the awareness that we are not entirely in our own hands.[41]

The context out of which I supervise is very much my faith in a creative and mysterious God who created us in God's own image and whose spirit "took flesh" in Jesus of Nazareth. Although intentional reflection about oneself, others, our world, and our future in community is my particular hermeneutical path as a CPE supervisor, growth in Christ remains the ground and horizon line of that reflection.

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[41] Leo O'Donovan, ed. *A World of Grace: An Introduction to the Themes and Foundations of Karl Rahner's Theology* (New York: Crossroads Publishing Co., 1991), 28.

CHAPTER 6

BIBLICAL/EXEGETICAL ANALYSIS

Two biblical narratives, the one of creation and the one of incarnation, continue to function as important stories in my development as a chaplain and pastoral educator. The story of creation, as found in the Book of Genesis and extra biblical literature, is a story where I hear of a God who created a world in which both creature and creator can meet and "walk together in the cool of the evening and talk." (Gen 3:8) I hear of persons, created in the "image" of their Creator, who were the first *hearers* of that creative word in a world that God saw as "very good." (Gen 1:31) Later, in the Gospel narratives, I hear a continuation and summing up of that same story of how God's creative word "became flesh and dwelt among us." (Jn1:14) I hear of Jesus' radical openness to and sharing of a presence with the holy that is mysteriously both ground and horizon of all human existence – something knowable, but not fully, something of the flesh, but also the spirit. And it is there, somewhere in those stories of creation and incarnation, with their lessons about transcendence and personhood, that I ground my pastoral ministry, as a chaplain and as an educator. If this created world is not something essentially apart from God, and I believe that it is not, and if we were created to actively participate in God's own creative activity, and I believe that we are all called to do that, then I also believe that our search for meaning *in this world* is really a search for God.

In my ministry as a chaplain, illness is often seen as an opportunity to search for new meaning in one's life. However, with mental illness this search can be confounded by cognitive deficits and developmental challenges. Nevertheless, people struggling with mental illness, like Anton Boisen years ago, do search for meaning in and through their illness. A patient at Penn Foundation named "Derek," not his real name, is an example of this.

Derek is a young man in his late 20's whom I have known for five years. He looks a bit like a 60's Bob Dylan, although his medications have made him much fatter. He was raised in a Christian family, but without any formal Christian education. Derek reads the Bible a lot and likes it when I help him study scripture. In general, Derek's ideas about God are homegrown and because of his obsessions, often viewed as "unhelpful" by his psychiatrist and therapist. Derek suffers from an acute obsessive-compulsive disorder (OCD) whose onset during his teenage years was accompanied by both alcohol and substance abuse. By his own account, Derek's alcohol and substance abuse was a way to self-medicate his feelings of *marginalization, exclusion, and oppression* by the wider society – areas I will explore in Chapter 9. Although what Derek experiences is not unique, his experience of mental illness is shared by many others who are in this same place. The hermeneutical theologian Mary Ann Tolbert writes that *location* informs how we read texts and struggle to find meaning there. "A poetics of location", she writes, "maintains the radical historicity of texts and interpreters, their creative and multiple interconnections, and their powerful constructions of reality, truth, and justice, in the hopes of persuading the world that those yearning for a better way finally need to be heard."[42]

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[42] Fernando F. Segovia and Mary Ann Tolbert, eds. "The Politics and Poetics of Location", *Reading from this Place*. vol. 1 (Minneapolis, MN, Augsburg Fortress Press, 1995), 317.

As a chaplain at a large Mennonite behavioral healthcare facility near Philadelphia, Pennsylvania, I minister from my place as a companion with those who struggle with debilitating mental illness and addictions, yet also struggle to find meaning in their lives. I balance this direct care with the pastoral supervision of seminarians, chaplains, and others who come to Penn Foundation for training. Behavioral healthcare can mean lots of things, but it always means the care of people struggling with mental illness. In behavioral healthcare, mental illness refers to a class of illnesses that profoundly influence a person's independent functionality and judgment.

Although the words "mental illness" do not appear in the Bible, there are a number of passages that refer to what appear to be the symptoms of a mental illness or states of mental disturbance. This is especially evident in the Hebrew Scriptures, which integrate a wide range of somatic and psychological language to express emotions. I will briefly comment on seven of these passages. I choose these seven because they have emerged repeatedly in contemporary Biblical commentaries or behavioral science literature as examples of mental illness in the Bible. As a pastoral theologian, it is my conviction that it is unhelpful to impose a modern sensibility or logic on these ancient texts, since they emerge from a culture that had no cognitive appreciation of mental illness as we know it today. In my work as a chaplain, I have repeatedly seen the dangers of this kind of isogesis, as certain Biblical texts are used to marginalize and stigmatize those who suffer from mental illness.

Deuteronomy, Chapter 28, refers to madness as a curse from God for breaking his commandments. As in other books of the Hebrew Bible, a distinction is made here

between diseases and illnesses caused by sin, as is the case here, and those caused by possession by evil. Chapter 28 is a warning by God to God's people.

1 Samuel 16:14-16 refers to Saul's possession by an evil spirit. Here, as in 1 Kings 22: 19-23, the etiology of Saul's despondency is divine: "and at times an evil spirit from the Lord would seize him suddenly." The scripture scholar Rodger Bufford attributes this curse to Saul's "sinful conduct."[43] "The early Hebrews believed that their one God, Yahweh, could send an evil spirit to afflict someone."[44] However, it is also important to note in 1 Samuel the behavior of the young David who, despite Saul's rage, provides soothing music for the disturbed King. I see in David's behavior a pastoral and non-judgmental response to Saul's tormented soul.

Daniel 4:15-22 refers to King Nebuchadnezzar's seven years of strange behavior - acting like a wild animal and eating grass. The scripture scholar Louis Hartman calls this behavior a symptom of "lycanthropy," a mental illness whose origins lie in Greek mythology. In Greek mythology a king of Aradia in western Greece by the name of Lycaon, decided to trick Zeus and was punished for it.[45] Later European folk tales about warewolves trace their origins to this same Greek myth. However, there is no historical evidence that King Nebuchadnezzar ever had lycantrophy or any other mental illness. In his same commentary, Hartman admits as much, saying that the folk tale surrounding

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[43] Rodger Bufford, *Counseling and the Demonic* (Dallas, Texas: Word Publishing, 1988), 37.

[44] T. Craig Issacs, "The Possessive States Disorder: The Diagnosis of Demonic Possession," Pastoral Psychology 35 (1987): 264.

[45] Louis F. Hartman, "Daniel", *The Jerome Biblical Commentary* (Englewood Cliffs, New Jersey: Prentice Hall, Inc., 1968), 453.

King Nebuchadnezzar probably originated in Babylon and was later attributed to Nebuchadnezzar.[46]

Although Psalm 22 has two parts, lament and thanksgiving, my work as a chaplain has often positioned me to hear this psalm as a song of lament. The lament of Isaiah 53 is often linked with Psalm 22. At Penn Foundation a number of patients have told me how often they read this psalm, as it gives concrete expression to the symptoms of their depression. Using the same psalm, I remind them that this Psalm 22 is really a song of deliverance, since the writer looks back on his desolation. It is from this place of deliverance and "looking back" that I pray for with my patients.

Judges 15-16 refers to Samson's violent and superhuman behavior. Whether these heroic events happened exactly as recorded in the Book of Judges or whether Samson's deeds were written by the hand of a later redactor, as the scripture scholar Dominic Crossan implies, it is clear that Samson's frightening deeds are all related to his eventual destruction of the Philistine temple.[47] It is clear in these chapters that Samson was heroic, exhausted, discouraged and madly in love. What is not clear to me is that he suffered from an antisocial personality disorder, as some have written.[48]

The Book of Ezekiel recounts the mission of the prophet Ezekiel who was sent by God to a scattered nation in turmoil. His mission was accompanied by voices and visions. The destruction of the temple and Jerusalem meant that the Jewish people in Diaspora could no longer rely on earlier liturgical and theological foundations for their survival. As

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[46] Ibid., 453.

[47] Dominic M. Crossan, "Judges," *The Jerome Biblical Commentary*, 160.

[48] See, for example, L. Altschuler, A. Haroun, B. Ho, and A. Weimer. "Did Samson have an antisocial personality disorder?" *Archives of General Psychiatry* 59 (2002): 565-6.

Ezekiel developed from a priest to a prophet, he spoke to his scattered people with the authority of one who knew what their losses meant. Ezekiel based his message on what he had heard and seen from God. Hearing voices and having visions were an integral part of the prophet's experience, as it was with many other Biblical characters, as it is in the experience of many people with mental illness. At Penn Foundation a number of patients who struggle with voices and visions have told me how difficult it is to sort out the good ones from the bad ones. My pastoral response includes both a question and a statement. The question is, "Is the voice you hear or the vision you see good for you or bad for you?" My statement is, "God would never ask you to harm yourself or others." Most of us, including people with mental illness, tend to hear and see God through our individual biases, blessing what we bless, cursing what we curse. However, this is especially confusing for people with a brain injury, as the very organ we use to sort things out, voices or visions, or whatever, is broken. As with the prophet Ezekiel and with people struggling with mental illness, discernment of voices and visions must take place within community.

Mark 5:1-20 refers to a man from the country of the Gerasenes possessed by an unclean spirit. From my experience as a chaplain, this passage is most often quoted as a clear reference to mental illness. However, I see it as primarily a passage about demonic possession. What is clear in this passage is the fact that the people not only feared the demonic in this man, but also the power of Jesus to control this demonic power. "Thus, they begged Jesus to leave their country," the scripture scholar Rodger Bufford notes.[49] Although older Biblical commentaries refer to this man as a "raving lunatic" and a

[49] Bufford, *Counseling and the Demonic,* 40.

"maniac,"[50] labels often associated with those who suffer from mental illness, it is important not loose sight of Mark's emphasis on the Messiahship of Jesus and the fact that even demonic spirits recognized this. From my reading of the literature, this story is more about demonic possession than mental illness. The Biblical scholar Ken Frieden focuses on the meaning of Jesus' exorcism by analyzing the words that Jesus uses to drive the evil spirit away.[51] After tracing the use of the keys words in ancient literature, Frieden acknowledges that within the dualism of the Mark text "Jesus stakes his claim as a divine representative on his ability to counter evil beings."[52] As a chaplain, I see hope in this passage, as good overcomes evil and a tormented person is made whole.

There is a natural tendency in human nature to look for the causes and origins of a person's strange behavior, even in the Bible. When we know "why" a person acts a certain way, then it seems easier to know how to respond. This is especially true with illness. Like other organs in our body, the brain too can malfunction. This helps to keep this kind of illness in perspective. As followers of Christ, what is important is not the origin of a person's suffering, but our response. This response involves reflection on our own attitudes toward illness and mental illness in particular, as well as our capacity to offer support to people who are suffering. Ideally, this support will be both individual and communal, as churches and church leaders acknowledge a full range of illness and dysfunction in their congregations and educate themselves and others about illness. With

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[50] Frederick C. Eislen et al., *eds., The Abingdon Bible Commentary*, (Nashville, Tennessee: Abingdon Press, 1929), 1006.

[51] Ken Frieden, "The Language of Demonic Possession: A Key-Word Analysis", in *The Daemonic Imagination: Biblical Text and Secular Story*, ed. Robert Detweiler and William G. Doty (Atlanta, Georgia: Scholars Press, 1990).

[52] Ibid., 48.

regard to mental illness, a logical place to begin would be to talk with people suffering from mental illness. As the psychiatrist Carroll Wise wrote over fifty years ago, "The problems of health cannot be adequately discussed without dealing with the experience of community and fellowship as recorded in the Bible. Anxiety is often the result of broken community; faith means trust in others and this creates and sustains community even as community contributes to faith."[53]

Community implies accountability. Christian accountability implies peership, especially in service to others. Although referring to women and people of color, another population struggling to find peership in North American society, scripture scholar Daniel Patte says that "Such accountability [to those we serve] can be conceived and achieved only by 'speaking with' those whom our traditional practices of biblical scholarship have marginalized, excluded, or oppressed, rather than 'speaking for them' or 'listening to them'".[54] My work as a chaplain has reminded me that people struggling with devastating mental illnesses have a long history of marginalization, exclusion, and oppression – their designated *places* in North American society. They also have a long history of companions who speak *for* or only listen *to* them. In fact, many professionals are educated and paid to do just that! As a chaplain to many of these same people, I am finally learning to speak *with* them. Recently, I learned to do this by offering my patients *a third voice* in our conversations – the Bible. In that gesture, I acknowledge that in my pastoral practice all conversations with me are really triadic, not dyadic, in nature. By this

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[53] Carroll Wise, *Psychiatry and the Bible* (New York: Harper and Row, 1956), 125.

[54] Segovia and Tolbert , eds., "Acknowledging the Contextual Character of Male, European-American Critical Exegesis: An Androcritical Perspective." *Reading from this Place,* vol. 1 (Minneapolis, Minnesota: Augsburg Fortress Press, 1995), 39-40.

I mean that the Bible is not just another "tool" in my pastoral care toolbox, but rather another living voice in that care – a voice we *both* can engage as peers.

CHAPTER 7

EDUCATIONAL ANALYSIS

The goal of all education is the assimilation of new experience into one's life. This assimilation is often accompanied by a new self-awareness. In Chapter 5 I suggested that this process of assimilation is really a process of personal integration a way of organizing experience *by giving meaning to it*. For, not until some experience, idea, or person is made meaningful in terms of a cognitive, affective, or behavioral context, can it be understood by us in a personal way. Or put differently, if something were totally meaningless to us, we would not, we could not, see it. Education, then, is a personal activity which deliberately attends to our *common need to know* and to the *future possibility* that knowing holds for the individual and the wider community. In Polanyi's language, we *dwell in* the meanings we are able to grasp, as we extend ourselves into that which we find coherent or congenial. Robert Kegan calls this indwelling and extension "a culture of embeddedness," which offers the learner the possibility of transformation.[55] For, to *dwell in* and *extend into* implies faith that the ground on which we stand and the horizon-line toward which we are moving are real and not a lie. If it is real, then it is something we need to continually seek after, question, understand, and eventually export or integrate. By faith I mean our capacity and willingness to admit that there is not only

[55] Kegan, *The Evolving Self*, 31.

an immanent and tellable quality about human experience (which includes knowledge), but also a transformative and tacit dimension as well.

This faith in our own experience, especially through the delivery of pastoral care in an educational community, has its roots in the early church, with the pastoral bishop and educator St. Augustine. Augustine's *Confessions* are Western Civilization's first attempt to write autobiography from the present tense. By reflecting on his past from his present experience, Augustine saw his past life differently. This is crucial to my own understanding of education. I believe that the educational process is not only an exploration of this or that part of our life experience, but an exegesis of the fundamental faith that lies underneath and the horizon-line that lies ahead of that individual experience. John Dewey put it this way: "Education is that reconstruction or reorganization of experience which adds to meaning of experience, and which increases our ability to direct the course of subsequent experience."[56] However, I prefer Augustine's succinctness: "*nisi credideritis, non intelligitis* – unless you believe, you cannot know."[57] Knowledge is personal precisely because it involves faith, which I believe is the context and necessary condition of all education.

An example of this educational process is when our daughter Karis was taking piano lessons. By the time she was eight, she had been playing the piano for over four years. Usually by my invitation, she practiced about twenty minutes every day. As a Suzuki parent, I understood my role in her educational process as one of *being attentive* to Karis in her learning, paying attention with her to both the music her fingers were making on the piano and the music she was hearing inside her head. As mentioned in

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[56] John Dewey, *Experience and Education* (New York: Macmillan, 1938), 89.

[57] Origin unknown, found in personal journal notes from 1979.

Chapter 5, Michael Polanyi identifies this goal of *being attentive* as the foundational goal of all learning. In my work as a pastoral educator, I am struck by just how frequently the goal of "learning how to be a better listener" makes its way into my students' learning contracts. "If you lift a camera to your eye," I used to tell my photography students, "it means that you are paying attention to something in a new way."

The goal of being attentive, of course, is to *become aware*. Polanyi notes four stages in this process of awareness: preparation, incubation, illumination, and verification.[58] He also notes two sides to one's awareness: subsidiary and focal.[59] Subsidiary refers to the awareness of tactility in Karis' fingers as she struck the piano keys - or the awareness of my students as they *practice* reflective listening during their pre-op visits. Focal refers to the feeling of making music with one's fingers - or the awareness my students' experiences during interpersonal seminars when they are sometimes very attentive to one another. Knowing *what* and knowing *how* are very close at this first stage of learning.

I understand the next stage of learning to be that of *reflection*. Reflection means showing and telling or putting our experience *out there,* where it can be examined and tested by others. At this crucial stage the learner begins to link praxis with understanding, so that the process of assimilation/integration may continue. Verbal articulation is the tool ordinarily chosen to demonstrate this linkage. This articulation of *where one is* in one's experience can take many forms. Primary among them in my CPE experience are expression of feelings (i.e., allowing others into our inner world), appeal to others for

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[58] Michael Polanyi, *Personal Knowledge: Toward a post-critical philosophy* (Chicago: University of Chicago Press, 1958), 121.

[59] Ibid., 43-4.

feedback (i.e., asking for validation), and stating the facts (i.e., narrating a story). An important part of what I do in CPE is to invite my students to wonder how their personal life experience informs their delivery of pastoral care. They do this by carefully scrutinizing their clinical material with their peers. At these creative intersections, where questioners and seekers reflect critically together, they become co-investigators in each other's learning. In that process personal knowledge is mediated.

"Even before you point your camera in a certain direction", I used to tell my students, "a lot of prior decisions went into particular one." Camera format, focal length of lens, shutter speed, lens aperture, and film elusion are the more obvious ones. *Decision-making* is the third stage in the discovery of knowledge. Decision-making has less to do with choosing this over that, than it does with our willingness to move beyond reflection. In consciously exercising our freedom to choose, we both define our world and actualize our *self*. By this I mean that we acknowledge both the limitations of our culture and move from a reflective subject to a decisive one. Polanyi sees that process "the lines of force in a heuristic field" confront the knower with "the opportunity" and "the resolve to make good this opportunity, in spite of its inherent uncertainties."[60] I believe that in exploring with our students' their movement from awareness to utilization, we are actually exploring this third and often conflictual stage of knowing.

Like the tool which acquires meaning through utilization, the sign or symbol acquires meaning only in the eyes of the person who relies on them to achieve or signify something. This reliance is a personal commitment which is involved in all acts of intelligence by which we integrate seemingly disparate things to the center of our focal

[60] Ibid., 403.

attention."[61] This fourth stage of knowledge, *commitment*, completes the assimilation of new experience by which we extend ourselves from indwelling to discovery. Commitment is that process by which the circle of personal knowledge turns back to *new* awareness, *new* reflection, and *new* opportunities for decision-making. Kegan uses the model of an "evolutionary helix" to describe the same process in human development.[62] As a pastoral educator, I believe strongly that commitment to the process of learning is crucial if the learner hopes to integrate not only new experiences, but also, like St. Augustine, what went before.

Validation is a process by which we come to appreciate and use the wider context of our growth as a meaningful instrument for interpreting our experience of self, others, and God. Validation is a way to test and generalize and thus integrate that experience into a meaningful reconstruction of self. I see the goal of validation as somewhat paradoxical – a deeper reliance and trust in our own inner dynamics linked with an acknowledgment of our need for continual connection to and reliance on others for "support, clarification, and support."[63] In his book *Theory and Practice of Group Psychotherapy*, Irwin Yalom contends that the process of adult self-learning is substantially different *in group* than it is one-to-one.[64] In my own CPE training, the weekly group process seminar tended to *the* locus of this group learning. As a supervisor, I have come to appreciate just how important the other areas of group work are: the

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[61] Ibid., 61.

[62] Kegan, *The Evolving Self*, 109.

[63] ACPE Standard 309.3. http://www.acpe.edu/acroread/2005_standards_manual.pdf. (accessed 29 November, 2006).

[64] Irwin Yalom, *The Theory and Practice of Group Psychotherapy* 3rd ed. (New York: Basic Books, 1985), 254-62.

informal gatherings, the clinical reflection seminars, staff and interdisciplinary team meetings, and daily worship. Groups gather for different reasons. Some gather to share experiences. Others gather to participate in joint activities. But even though groups gather for different reasons, I have noticed that we adults tend to think, feel, and act the same way in whatever group we join. Yalom refers to this when he describes every group as "a social microcosm."[65] I have also noticed in CPE how quickly people assume certain roles in group, roles that are often consistent with their roles in other contexts. With that experience, I see an important part of my work as a supervisor is to clarify with my students *how* they are with others. In the interpersonal relationship seminar I help my students understand not only how groups function, but also how he or she functions in a group.

Up to this point, I have explored the process of learning: acquisition or mastery of what is already known by others, an indwelling and extension of the meanings of one's individual experience, and a process in which one tests ideas and generalizations relevant to some personal problem in a community of peers. Building on this understanding of supervision, I will now explore the implications of creating "zones of mediation" where my students can shape the objectives and outcomes of CPE for themselves.[66]

Creating structures where learning can take place means creating certain conditions where learning can take place. The adult educational theorist Malcolm Knowles identifies five conditions for learning, the fifth of which is central to this

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[65] Ibid., 30.

[66] Kegan, *The Evolving Self*, 2.

demonstration project.[67] With these five, I have linked five questions which have accompanied me in this demonstration project. Knowles writes that:

1. There must be an environment creative enough to offer the student both the safety and stimulation to learn. This means that the dual role of minister/student must *both* be acknowledged if a student is to learn by doing. What evidence is there that the student possesses the capacity to risk learning something new?
2. There must be an openness to allow the student some measure of interdependence and autonomy to change. This means that an acknowledgement of a student's capacity to learn varies with each student's life-story. How does supervision heavily informed by mutual gift discernment affect a CPE student's learning?
3. There must be some sense of questioning or searching after meaning in a student's life. This means that the student is not a finished product, but someone in process. Is the student willing to assimilate new experience in the acquisition and maintenance of a ministerial self?
4. There must be some relevance in establishing and maintaining peer relationships with others. This means that the use of one's peers in the learning process is an important stage in a student's growth as a minister. How well does the student use support, clarification, and confrontation in group?
5. There must be a sense of satisfaction that one is, in reality, learning. How well are a student's expectations and needs met in this kind of learning?

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[67] Malcolm Knowles, *The Modern Practice of Adult Education: from Pedagogy to Andragogy* (Chicago: Follett Publishing Co., 1980), 57-8.

Clinical pastoral education is a context for practical learning about oneself as a minister. In this chapter, I have attempted to outline what the goals of this adult learning are, as well as the conditions for such learning. In emphasizing the faith that students need to possess in themselves as learners and the faith that we need to possess in this particular process of learning, I have perhaps inadvertently side-stepped another kind of faith: the faith that I have in my students to learn. Fundamental to my understanding of supervision is the belief that my students *can* learn. This belief is not born of sentimental material, but a genuine concern for the common ground on which we stand and particular horizon-line toward which we are headed. It is, as Adrienne Rich once remarked, a very demanding matter of "realistically conceiving the student where he or she is, and at the same time never loosing sight of where he or she can be."[68]

[68] Origin unknown, found in personal journal notes from 1990.

CHAPTER 8

SOCIAL JUSTICE ANALYSIS

We already live in an era of evidence-based medicine and outcome-based education. Understanding how we got here and why we stay here implies an understanding of how power and justice function in American society. This chapter will explore those understandings from the perspective of fee-for-service medicine (Penn Foundation) and outcome-based education (Clinical Pastoral Education). I begin with the bias that power is a dynamic in all human relationships and that justice involves both fair treatment and an equitable distribution of resources.

From the perspective of medicine and education, six questions emerge:

1. What forces fuel the predominance of fee-for-service medicine in our society?
2. What forces resist the movement of "healthcare coverage for all?"
3. What forces currently resist parity in behavioral healthcare resources and choices?
4. What justice issues emerge in our current delivery of behavioral healthcare?
5. What are the challenges of outcome-based education?
6. What are the challenges of outcome-based CPE?

In some ways, these questions frame the justice issue, for the way we look at problems affects how we try and solve them. In the area of mental illness and mental health, however, it is important to look at both the suffering individual *and* the world in

which that person lives. A number of patient and ex-patient advocacy groups like the National Alliance on Mental Illness (NAMI) and the National Empowerment Center (NEC) and the final report of the Presidential Commission on Mental Health do both.[69]

If fee-for-service medicine is the only world in which people with mental illness are diagnosed and treated, what fuels this culture and industry? As is the case with education in America, ideas and attitudes fuel behavior. Although much of the current debate about healthcare coverage in America is political and revolves around public policy, it is really *ideas* about healthcare and the funding of healthcare that fuel our fee-for-service healthcare industry.

Malcolm Gladwell calls the primary idea fueling opposition to universal healthcare coverage in America the "moral hazard myth."[70] Moral hazard is the term economists use to describe how ideas about behavior actually control behavior. As an example, "If your office gives you and your co-workers all the free Pepsi you want – if your employer, in effect, offers universal Pepsi insurance – you'll drink more Pepsi than you would otherwise. If you have a no-deductible fire insurance policy, you may be less diligent in clearing the brush away from your house"[71] What behavior does this idea produce within the health insurance industry? The word that best describes this behavior is *caution*. Caution - marked by pre-certifications, co-payments, deductibles, and utilization reviews. Caution – marked by a fear that accessibility will drive consumption.

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[69] These organizations and this report can be accessed at www.nami.org; www.power2u.org; www.mentalhealthcommission.gov. (accessed 2 February, 2007)

[70] Malcolm Gladwell, "The Moral Hazard Myth: The bad idea behind our failed health-care system," *New Yorker* 29 (August 2005): available at http://www.Gladwell.com, 3. (accessed 3 August, 2006).

[71] Ibid., 3.

Caution – marked by the absence of a political will to intervene. Consequently, a large number of Americans remain uninsured because no one will insure them. The numbers alone are staggering. Forty-five million people are uninsured in America today, one/third of who live below the Federal poverty line.[72]

Underneath all caution is some form of fear. Historically, opposition to universal health coverage emerged from three fears: socialism, big government, and the Moral Hazard Myth, mentioned above.[73] These fears generate fantasies of a healthcare free-for-all with millions of people running to their doctor for every little sore throat, or just as bad, millions of people lined up to receive their ration of healthcare. However, opposition to universal healthcare coverage means that everyone is paying for each other's coverage in other ways. Whether it is high premiums for the uninsured, higher taxes, or higher medical bills, we all pay – directly or indirectly for each other's healthcare. Answers to the social justice questions of "How fair is this current state of affairs?" and "Can we do better?" are "Not" and "Yes." These answers are based on a cursory comparison of our fee-for-service healthcare against industrialized countries.

The facts alone are disturbing:

- The leading cause of bankruptcy in America is unpaid medical bills.
- Americans spend $5,267 per capita on healthcare every year, almost two and half times the industrialized world's median or $2,193.
- Americans have fewer doctors per capita than most Western countries.
- Americans go to doctors less frequently than people in other Western countries.

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[72] Ibid., 715.

[73] Opposition to universal healthcare coverage can be found at http://www.liberty-page.com/issues/healthcare/socialized.html.(accessed 26 January, 2007).

- ❖ We are less satisfied with our healthcare than our counterparts in other countries.
- ❖ American life expectancy is lower than Western Europe.
- ❖ Our childhood immunization rates are lower than the average industrialized country.
- ❖ Our infant mortality rates are in the nineteenth percentile of industrialized nation
- ❖ We spend more than $1000 per capita per year on healthcare paperwork and related administration, while Canada, for example, pays only about $ 300 per capita.[74]

These facts raise other justice issues, including fair treatment, equitable distribution of resources, and the uneven coverage for those with mental illness.

If power and control are the dominant forces in a system, then the arbiters of what is fair or not fair, what is equitable or not equitable, and who benefits and who is left out are often the stakeholders in the evaluation process. Who are the stakeholders in healthcare? They are insurance, pharmaceutical, medical technology, and managed care companies on the one side, with patient advocacy groups, consumers, and an increasingly worried public on the other. Unfortunately, this debate has also become so strongly politicized that we are at the point of polarization and paralysis.

An available window into the complicated justice issues surrounding healthcare in America today is the window of the managed care industry. Managed care emerged in the 1970's to contain sky-rocketing medical costs. Almost overnight and by Congressional mandate, managed care became federal law with the U.S. Health Maintenance Act (HMO) of 1973. Managed care quickly became the primary vehicle for healthcare

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[74] Gladwell, 2-3.

delivery in the United States. It was not long before words like pre-certification, utilization review, and capitation entered the vocabulary of healthcare providers. For the third party insurer, managed care meant gate-keeping and cost containment by rationing and commodifying care, case-by-case, into "goods and services" and "customers." For the behavioral healthcare provider, managed care meant shifting from a traditional biopsychosocial model to one that now "must meet standards of medical necessity and efficiency"[75] and can be scientifically validated as efficacious. For the consumer, managed care often meant limited care. The difficulty in assessing the exact origins of mental illness and consensus around the effectiveness of so many treatment options only compounded the issue for many behavioral healthcare providers and consumers.

This new legislation forced new developments in how behavioral healthcare, a sub-specialty in medicine, was taught, reimbursed, and delivered.[76] In 1990 this legislation joined another piece of federal legislation that had a profound affect on the delivery of healthcare in America – the Patient Self-Determination Act. Some have noted that it was during these twenty years that psychiatry, considered by the scientific community as the least scientific of the medical sciences, became even more defensive, struggling to adopt a more biomedical concept of mental illness.[77] Healthcare analyst Teresa Scheid also notes that free market forces and the commodification of healthcare

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[75] See Teresa Scheid, "Rethinking the professional prerogative," *Sociology of Health and Illness* 22 (2000): 700-719.

[76] For a fuller appreciation of this shift, see especially Lisa M. Sanchez, and Samuel M. Turner, "Practicing psychology in the era of managed care: Implications for practice and training," *American Psychologist* 58 (2003): 116-29.

[77] For a critique of this development, see Thomas R. V. Nys and Mauritius Nys, "Psychiatry under pressure: Reflections on psychiatry's drift towards a reductionist biomedical concept of mental illness," *Medicine, Health Care and Philosophy* 9 (2006): 107-115.

delivery system also play significant roles in the movement to managed behavioral healthcare.[78] The danger with commodification is that it neatly translates and packages a complicated system of healthcare into the language of business. In the language of products and services, target goals and bottom lines, people sometimes get left out. When this culture becomes politicized, polarization and paralysis can set in. When this happens, it is often the poor and the elderly who are the most vulnerable. As an example, the government has recently tightened Medicare coverage by requiring patient participation in relevant research, registries and clinical trials.[79] Physician advocates challenge the justice of this requirement, raising questions about "coercion," "risk," and "fairness."[80]

The forces of managed care have also caused a dramatic shift in the division of labor and practice in behavioral healthcare. Cost-effectiveness and a reorganization of the professional standards of care now permit licensed social workers and counselors to do much of the work once done by psychiatrists and psychologists. Psychiatrists now see patients primarily for intake evaluations and medication assessments.

As mentioned in Chapter 2, behavioral healthcare was founded on moral and professionally determined imperatives and somewhat ambiguous goals, so that psychiatry has been see differently than other branches of medicine. Additionally, before the emergence of "biological" psychiatry and neurology, there was little agreement about treatment options for the same mental illness. Behavioral healthcare providers often used

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[78] Scheid, 700.

[79] See Steven D. Pearson, Franklin G. Miller, and Ezekiel J. Emmanuel, "Medicare's Requirement for Research Participation as a Condition of Coverage." *Journal of the American Medical Association* 296 (August 2006): 988-91.

[80] Ibid., 989.

a combination of treatment options with their patients. These included psychotherapy, medication, rehabilitation, and other types of treatment.

In this new culture of managed behavioral healthcare, ethical dilemmas involving justice arise because of conflicts between professionally based standards of care and newly emerging standards of evidence, fiscal savings and profit. True, managed care has brought two different approaches to treatment, psychotherapy and psychopharmacology, closer together. Yet, it has fueled another debate, this one about equal coverage for mental illness by insurance carriers, called "parity." The "President's New Freedom Commission on Mental Health - Achieving the Promise: Transforming Mental Health Care in America" expresses full support for parity, although federal bills mandating parity continue to fail in Congress and only a handful of states have addressed parity as a justice issue. From where I minister, national legislation on parity would accomplish two just goals: make health care affordable for a great majority of Americans and de-stigmatize mental illness.

Stigmatization describes discrimination against those struggling with mental illness. This discrimination, like all discrimination, covers a whole range of multiple, seemingly insignificant indignities that a person with a mental illness experiences every day. As with other discriminations, this type rests on the ideas and assumptions our society has about mental illness. Some of these ideas, called "Myths" on NAMI's educational web page, label people with mental illness as "disabled, unpredictable, unproductive, and potentially violent."[81]

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[81] See http://www.nami.org/Template.cfm?Section=Fight_Stigma&Template=/TaggedPage/TaggedPageDisplay.cfm&TPLID=77&ContentID=39706. (accessed 1 February, 2007).

Mental health advocates Patrick Corrigan and Robert Lundin reflect on the disabling power of these myths in their book *Don't Call Me Nuts!* "The discrimination that results from this [stigmatization] can be as disabling as the illness itself. It is an undisputed fact that people with mental illness are unable to get fulfilling jobs and find comfortable housing *not* because of the symptoms of their mental illness, but because of the discrimination that results from misconceptions about their illness."[82] They suggest six ways to foster personal empowerment:

1. Move from a position of noncompliance to one of collaboration with your provider;
2. Let your provider know how satisfied/dissatisfied you are with their care;
3. Join a Clubhouse;
4. Get involved in an assertive treatment program;
5. Join self-help and consumer-operated services;
6. Participate in research studies.

Following deinstitutionalization in the 1960's, societal denial, neglect and imprisonment of those who suffer from mental illness is now a clearly a social justice issue. With a long history of care for those who suffer and are without a strong political voice, the church must do its part to address this national scandal in our healthcare system. At Penn Foundation, I have been privileged to address church groups and clergy in this area. I normally finish my presentation with four practical suggestions on how to proceed: discuss your assumptions and biases about mental illness with one another in the church, educate yourself and your church about mental illness, get to know people who

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[82] Patrick Corrigan and Robert Lundin, *Don't Call Me Nuts!* (Tinley Park, Illinois: Recovery Press, 2001), 1-2.

suffer from mental illness and make them feel included in your church, and become advocates for those struggling to *recover* from a mental illness.

Is "recovery" from mental illness possible? The "President's New Freedom Commission on Mental Health - Achieving the Promise: Transforming Mental Health Care in America" believes so, as do many people I minister to here at Penn Foundation.[83] In a recent retreat at Penn Foundation's Wellspring Clubhouse, people were asked to express what "recovery" meant to them. Their descriptions included "living life to the fullest, being part of a community, getting a job, going to school, symptom-free living, and having dreams again."

Since mental illnesses rank first among illnesses that cause disability and are under-recognized as a public health burden, the President's Commission rightly sees recovery as an issue of justice.[84] The commission recommends six national goals:

1. Americans understand that mental health is essential to overall health;
2. Mental health care is consumer- and family-driven;
3. Disparities in mental health services are eliminated;
4. Early mental health screening, assessment and referral to services are common practice;
5. Excellent mental health care is delivered and research is accelerated;
6. Technology is used to access mental health care and information.

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[83] The "President's New Freedom Commission on Mental Health - Achieving the Promise: Transforming Mental Health Care in America" can be found at www.mentalhealthcommission.gov/reports/Final Report/Full Report-03.htm. (accessed 2 June, 2006).

[84] Ibid., "Goal 2 - Mental Health is Consumer and Family Driven," 2.

In that light, the conditions that make recovery possible also become justice issues involving political will and shifts in our public policy. This will mean the reorganization of health care programs that currently serve people with mental illness, community education and equal coverage (parity) for people with mental illness, and active consumer and community participation in treatment approaches. The goals of the President's Commission are large and challenging. However, the cost of doing nothing or adjusting and readjusting to a broken and fragmented healthcare system will be unfairly carried by everyone involved in our healthcare system: providers, patients, and the wider community.

CHAPTER 9

IMPLICATIONS FOR PASTORAL CARE AND EDUCATION

> "Not everything that can be measured, matters;
> and not everything that matters can be measured."
> (Albert Einstein)[85]

This demonstration project had three goals:

1. Identify if early indicators of students' competencies are reliable predictors of future CPE outcomes;
2. Identify whether an intentional focus on CPE students' gifts and strengths would reliably predicts future learning outcomes;
3. Explore and compare the paradigmatic shifts and challenges in moving from pathology-based behavioral medicine and clinical pastoral education to outcome-based medicine and education.

Evidence-based behavioral healthcare and outcome-based CPE have developed substantially from their origins in evidence-based medicine and outcome-based education. Although these developments have been difficult for both practitioner and consumer, there seems to be no way back to the days when physicians or educators were only accountable to their professional colleagues. As sub-specialties of medicine and

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[85] As quoted in the *British Medical Journal* 324 (2002); 1247, *http://www.bmj.com/cgi/eletters/324/7348/1247#22665*. (accessed 22 December, 2006).

education, behavioral healthcare and CPE have also developed - largely in response to the powerful historical and cultural forces mentioned in Chapters 2 and 3. In some ways behavioral healthcare and CPE have become less pretentious and esoteric, as both disciplines negotiate best practices and the relevance of on-going research, communicate honestly with colleagues, patients, students, and public policy makers, and keep an eye on issues of distributive justice and individual autonomy.

This demonstration project revealed a number of pastoral implications for my own future delivery of pastoral care and supervision and, by extension, my CPE chaplain and supervisory colleagues. My research also revealed an important implication for the organizations that certify us and accredit our programs.

As a chaplain in behavioral healthcare, a number of pastoral implications emerged from this demonstration project. My research has taught me that behavioral healthcare is not a perfect science and does not neatly fit into the biological model of medicine. This means that as a chaplain I need to be curious about my patients - how I *read* them and how I *read* myself when I am with them - a curiosity that will position me to speak *with* them, not *to* them or *for* them. This awareness now causes me to ask a number of questions. Among them: What are the biases and assumptions I bring to my ministry? How do I understand the etiology of their illness? How they are doing with their psychotropic medications? What is their quality of life, capacity for hope and participation in their recovery? What are the cultural pressures that continue to marginalize and stigmatize people with mental illness? What role can the church play in advocating for people who have no political voice?

My readings in hermeneutical theology have heightened my awareness of how I use the Bible during my pastoral visits. In the future, for example, I will practice pastoral intertextuality by remembering that scripture can be a "third" voice in my pastoral conversations. Additionally, my reading in the area of social justice has heightened my awareness of just how difficult it is for a healthcare provider and educator to grasp the problems of healthcare in America today. I am now committed to read more in the area of public health, with particular attention to behavioral health.

As a CPE supervisor, this demonstration project has made me more aware of the historical and philosophical foundations of the ACPE outcomes. This awareness has helped me appreciate the outcomes as best practices in pastoral care. Surprisingly, I learned that the cultural pressures on CPE to change have been both new and old. The newer pressures were external, as CPE struggled to adapt to ever-changing educational technology, competing forces in the development of adult educational theory, and a global market. The older pressures, though, have been with CPE since its inception in the 1920's. I have noted certain historical connections with the following pastoral educational implications of my demonstration project. They are:

- The necessity of further research in the field of clinical pastoral education (Helen Flanders Dunbar);
- Renewed interest in the use of self, especially the wounded self, in the pastoral encounter (Anton Boisen);
- Honest discussion in the pastoral care literature about what constitutes best practices in pastoral care and pastoral education (Richard Cabot and Helen Flanders Dunbar);

- ❖ Consensus among pastoral care certifying and accrediting organizations about what constitutes these best practices (The Institute for Pastoral Care in Boston vs. The Council for Clinical Training in New York);
- ❖ A conscious effort in our CPE curricula toward the acquisition of measurable pastoral skills (Richard Cabot).

As in the case of evidence-based medicine and behavioral healthcare, this demonstration project reminded me that the paradigm shift to outcome-based CPE will not go away any time soon. However, this paradigm shift will be shaped by at least three cultural forces: ACPE's capacity to articulate and a CPE supervisor's capacity to measure learning outcomes as best practices in pastoral care, as well as all pastoral care accrediting and certifying organization's consensus on what those best practices look like.

What are the pastoral implications of this paradigm shift? First of all, outcome-based CPE requires new skills of the supervisor, including efficient literature search on effective supervisory practice. This means that the study of learning problems and resistance to learning are necessary, but are insufficient guides for supervisory practice. Second, supervisory instincts need to be based on educational evidence, not training in other disciplines, e.g., pastoral psychology. And finally, effective supervisory practice demands the capacity to review and do systematic and rigorous educational research. Outcome-based CPE deals directly with the uncertainties of experiential learning and has the potential of not only safely framing that learning, but transforming the supervisory practice of the next generation of CPE supervisors.

Given the work I did in this demonstration project, I would make three recommendations to my supervisory colleagues:

1. Intentionally utilize CPE outcomes in your practice. This will involve reading about how these outcomes reflect or do not reflect your understanding of best practices in pastoral care.
2. Collect your data. If you cannot do this, hire someone who can.
3. Quantify your evidence. This means measuring demonstrated learning, using measurements that are congruent with your education theories.

Barriers to implementation of outcome-based CPE include:

- pastoral organizational impasses in dialog; lack of consensus about best practices and how to honor *both* student learning goals *and* the outcomes of CPE;
- autocratic and authoritarian CPE supervisors, many of whom have rudimentary educational assessment skills or cannot articulate their supervisory theory;
- resistance to change by older CPE supervisors; viewing outcome-based CPE as "Cookbook CPE";
- the lack of research in the effectiveness of outcome-based CPE.

The competency rating scales, found in appendix D, were my demonstration project's primary research tool to measure CPE students' perceived learning over fifteen weeks. The self-assessment graphs, found in appendixes H and I, charted this learning. The graphs do not indicate a smooth learning curve from levels of incompetence to competence. Rather, they indicate that student self-assessment of their competencies was

generally high *before* CPE and then fluctuated dramatically *during* CPE. What are the pastoral implications as shown by these graphs?

This fluctuation from perceived competency to incompetency sent me back to learning theories about competency. I learned that this fluctuation can be understood as a movement through four distinct stages of learning awareness. The origins of these stages of learning, I discovered, were not entirely clear. However, the Gordon Training International organization, once famous for its Parent Effectiveness Training seminars, publish them.[86] In a nutshell, the stages of my CPE students' learning followed a familiar pattern. According to this theory, every learner begins at Stage 1 with unconscious incompetence - an unawareness of what they do not know and do not know they do not know. In Stage 2, learners begin to become aware of what they do not know. In Stage 3, learners become aware of what they were learning. In Stage 4, learners are unaware of what they have learned because they have already assimilated this into their identity and functioning.

The graphs record that, in general, before CPE began most students assessed their competence as high, even though they had never measured themselves against this particular outcome before. The only exception to this is pastoral role/identity, which remained generally low throughout the fifteen weeks of CPE. In other words, before CPE began, my students were unaware of what they did not know. Later, as they began to minister and measure themselves against a particular outcome, they became aware of what they did not know. About mid way through CPE, some of my students became aware of their competence in a particular outcome. As they continue their CPE learning,

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[86] Information about Gordon International can be found at http://www.gordontraining.com/index.html. (accessed 16 January, 2007).

it is my hope that they will be unaware of their competence in certain areas and "just do it." There is no indication that my CPE students are at this stage just yet.

These graphs taught me that the assimilation of new experience and learning into my students' lives is a complex process. CPE required of them new competencies to respond to the "living human documents" they encountered in their new ministry. Educational theorists like Robert Kegan point out that adult education is indeed a complicated process, requiring the assimilation of new experience within evolving systems. In his latest book, Kegan suggests that this process of assimilation is really a developmental movement through multiple levels of competency and incompetency.[87] As these graphs also point out, CPE provided an educational frame of reference for experiential and developmental learning to occur. This frame of reference included stimulation for learning in a clinical setting; a learning contract between the CPE student and supervisor; measurable learning outcomes; tools for reflection, such as didactics, workshops, reflection papers, verbatims, staff evaluations, an exit interview, an ACPE consumer report form, self-evaluations, supervisory evaluations; group supervision; and individual supervision.

These graphs also revealed an important piece of information for my supervisory practice. One of my Level 2 CPE students, Student 1, scored low and remained low for the first competency: "I can articulate an understanding of my pastoral role that is congruent with my values, basic assumptions, and personhood," and two of my Level 1 CPE students, students 2 and 3, scored low and remained low for their first competency: "I can clearly articulate the central themes of my religious heritage and the theological

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[87] Robert Kegan, *In Over our Heads: The Mental Demands of Modern Life* (Cambridge, Massachusetts: Harvard University Press, 2000). 291.

understanding that informs my ministry." Both of these competencies revolve around one's pastoral role and religious heritage. In the future, I will be in a better position to ask why there was not any or much movement in these two important areas of pastoral competence, as well as wonder if I may need to reexamine my CPE curriculum or shift my supervisory methodology to respond to this lack of movement.

The exit interview report, found in appendix G, was a helpful educational tool and taught me that a CPE student's understanding and articulation of learning does not happen automatically when a CPE supervisor changes his supervisory style. In the report, for example, there was no mention of "gift" or "gift discernment" language by my students.

As outcome-based CPE continues to de-emphasize intuition, unsystematic clinical experience, and pathology as supervisory strategies and it stresses the systematic examination of evidence from experience, CPE will continue to change. "Adults like to learn in relevant, out-come oriented environments and that by reflecting on their experiences in light of the outcomes they are trying to achieve they learn not only more effectively but actively take responsibility for their learning."[88] Although Reg Derrick wrote this about medical education, I believe that the same can be said about pastoral education, for without an eye on certain outcomes, doing CPE is like going on a trip without a map.

As with sound theology, however, this demonstration project raises more questions than it answers. These questions revolve around the future of evidence-based

[88] Reg Derrick, "Justifications for learning outcomes: more appropriate educational theories." *Medical Education* 38: (2004), 1203.

behavioral healthcare in America and the future of outcome-based CPE in ministerial education.

In a culture of evidence-based medicine, the questions are large. Will there be the political will to fix a national healthcare system that is clearly broken? Who will control the universal medical coverage debate? How do the forces of managed care and patient autonomy, medical technology and pharmacology inform not only the bottom line, but the health of our nation? Will there be national or state-by-state legislation to guarantee parity for those who suffer from mental illness? Will mental health assessment devolve to outcomes, care plans, and patient satisfaction surveys?

In a culture of outcome-based education, the questions are not as large, but just as important. How will the pressures of "teaching to the outcome" affect the CPE? Will ACPE and other accrediting/certifying organizations reach consensus as to the best practices in the delivery of pastoral care and supervision? Will the historical emphases, tensions, and conflicts between Anton Boisen, Richard Cabot, Helen Flanders Dunbar, The Institute for Pastoral Care in Boston and The Council for Clinical Training in New York ever be resolved? How will future research into the educational and pastoral effectiveness of particular CPE programs inform the wider movement?

Although the answers to these questions may be difficult to imagine, it is important to remember that those who ask or answer them may not be the primary stakeholders in the process of healthcare and educational renewal. The real stakeholders are the patients and students whose healthcare and learning is in the hands of their providers and educators. Therefore, it is we who must be ever-vigilant about the forces

that inform and shape our care and education, while at the same time staying informed about what constitutes best practices for those we serve.

CHAPTER 10

COMPARABLE MINISTRIES

As a pastoral care provider and educator, my colleagues in ministry minister primarily in three fields: pastoral care and counseling, behavioral healthcare, and CPE. As a pastoral care provider and theological educator in the area of behavioral healthcare, where all three disciplines converge, I am in a unique place to observe the ministerial challenges of providing pastoral care and education "under the same roof." However, this unique place of pastoral care and education sets me apart from my colleagues and has made it difficult to identify comparable ministries in my field of research.

Although its historic roots are in mental health and the ACPE web site lists mental health facilities as typical clinical sites, very few CPE supervisors actually minister and teach CPE in behavioral healthcare programs.[89] Of the 350 CPE centers on its web site, ACPE lists only five "psychiatric hospitals" and one "mental health center" (Penn Foundation).[90] They are:

- C. M. Tucker Jr. Nursing Care Center, Columbia, SC, ACPE Supervisor Mary Rae Waller;
- Oregon State Hospital, Salem, OR, ACPE Supervisor Roy M. Tribe;

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[89] ACPE accredited sites are at http://www.acpe.edu/directories.htm. (accessed 22, December, 2006).

[90] Ibid.

- Penn Foundation, Sellersville, PA ACPE Supervisor Carl Yusavitz;
- Philhaven, Mount Gretna, PA, no active ACPE Supervisor;
- Saint Elizabeth's Hospital, Washington, DC, ACPE Supervisors Vickie Cowell and Clark S. Aist;
- Westborough State Hospital, Westborough, MA, ACPE Supervisor John Weagraff, Jr.

In January 2007 I contacted my supervisory colleagues at the four ACPE centers that still listed a supervisor. I asked them to share with me their supervisory curriculum and reflections on their experience in a comparable ministry. I heard from three of my CPE colleagues listed above, although only one center actually responded to my request for information.

One colleague informed me that her facility no longer does behavioral healthcare. Instead, their CPE program focuses on ministry to the elderly in a continual care facility. Another colleague informed me that his pastoral care team is so understaffed that they are unable to focus on behavioral healthcare issues. The only comparable ministry program that sent me information was on the St. Elizabeth's Hospital CPE program in Washington, DC. They shared with me their Standards of Care, Small Group Protocols, Spiritual Assessment Forms, and CPE Curriculum.

A review of the documents from my colleagues at St. Elizabeth's Hospital gave me what I needed to compare our ministries. Although St. Elizabeth's is primarily an in-patient acute care behavioral healthcare hospital, I was able to learn how I might more effectively improve the ministry I do in a primarily out-patient behavioral healthcare facility.

St. Elizabeth's Standards of Care document listed nine pastoral "problems," "expected outcomes," and "interventions." Seven of these pastoral situations resonated with what I encounter at Penn Foundation:

1. Behavioral dysfunction accompanied by religious ideation associated with a mental disorder;
2. Substance abuse/dependence with a spiritual orientation;
3. Cognitive dysfunction;
4. Conduct disorder with children and youth;
5. Antisocial behavior;
6. Psychosis, accompanied by disorders of thought, perception, and behavior;
7. Disturbances of mood.

I appreciated two things about St. Elizabeth's Standards of Care: their clear diagnostic categories and expected outcomes. My CPE program at Penn Foundation does not minister from a Standards of Care model of patient/client/resident care. Instead, my student placements all have job descriptions that my CPE preceptors use to measure student learning. I evaluate my students' learning based on their learning goals and the outcomes of Level 1 and Level 2 CPE. St. Elizabeth's Standards of Care document offers me new language to revise my students' job description.

St. Elizabeth's Small Group Protocols reflect the ministry that I and my CPE students do with two comparable programs at Penn Foundation: our psychosocial rehabilitation and dual diagnosis programs. Although St. Elizabeth's did not share with me their spirituality curriculum for these small groups, I felt confident that given their description of these small groups, the curriculum already developed at Penn Foundation

was comparable to that of St. Elizabeth's. Our curriculum is based on the book *Working with Groups on Spiritual Themes: Structured Exercised in Healing*, vol. 2.[91] Over the past five years my CPE students have also designed their own spirituality group outlines and worksheets. These are available for future CPE students in two 3-ring binders in the Pastoral Services library.

St. Elizabeth's Spiritual Needs Assessment Form reflects the need for concise in-patient charting. Since we do not have a large in-patient population at Penn Foundation, this form had limited usefulness. However, my CPE students do chart and participate in spiritual assessments in the Recovery Center, the behavioral healthcare unit at the hospital, and at our various retirement communities. The St. Elizabeth's form is comparable to how I orient my CPE students to the clinical placements that require or encourage charting. My charting model is the "PIE" model of charting: What is the Problem? What was your Intervention? How do you Evaluate your ministry? In their CPE verbatim sessions, I also encourage assessment by reminding my students of six simple questions: What is the patient's problem? What are their strengths in solving this problem? What limits their solving their problem? What is your pastoral intention with this patient? What are your strengths in implementing your intention? What limits your implementation?

Since St. Elizabeth's is a psychiatric hospital, their CPE curriculum focuses primarily on behavioral healthcare ministry. Their CPE orientation, weekly small group process seminars, verbatim seminars, faith journey presentations, and six didactic

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[91] Elaine Hopkins, Zo Woods, Russell Kelly. Katrina Bentley, and James Murphy, *Working with Groups on Spiritual Themes: Structured Exercised in Healing,* vol. 2 (Duluth, MN: Whole Person Associates, 1995).

presentations on mental health ministry are comparable to what I do in my CPE program at Penn Foundation. However, their morning report, administrative meetings, and presentations on charting and record-keeping all reflect the culture of a hospital-based CPE program.

Apart from the educational practitioners mentioned above, a number of pastoral theologians have explored the worlds of mental illness and addiction and pastoral supervision in various books and articles. All of these authors write about their experience of pastoral care with people struggling with debilitating mental illnesses and, in some cases, their education of others in that ministry. Their work has offered me new metaphors and models of pastoral care and supervision.

After years of ministry as a psychiatric chaplain, John Swinton now teaches practical theology at King's College, University of Aberdeen, in Scotland. His pastoral care and education are comparable ministries in that his models of care and education, like mine, emerged directly from his experience of direct care. I especially resonate with Swinton's metaphors of friendship and liberation for those who serve persons with mental illness.[92]

Richard Dayringer is a professor of psychosocial care and Chief of the Department of Behavioral Sciences at Southern Illinois University. He is also an ordained minister and pastoral counselor. Dayringer's specialty is depression, a devastating illness shared by many people I care for at Penn Foundation. In his book, *Dealing with Depression*, Dayringer offers five interventions for pastors to minister to members of

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[92] John Swinton, *Resurrecting the Person: Friendship and the Care of People with Mental Health Problems* (Nashville, TN: Abingdon Press, 2000).

their churches who suffer from depression.[93] These interventions include pastoral counseling, Gestalt therapy, behavior therapy, cognitive therapy, and transactional analysis. The only comparative pastoral intervention I and my CPE students practice is pastoral counseling. Nonetheless, Dayringer's overall ministry is comparable to mine in that he both ministers to people with depression and teaches about it. His work is an important contribution to my own ministry of education, since I teach seminarians and community pastors, many of whom feel helpless with people struggling with depression.

Stewart D. Govig has written and preached extensively on ministry to people with mental illness. His book, *In the Shadow of our Steeples: Pastoral Presence for Families Coping with Mental Illness*, is based on his family's struggles with their own son who suffered from schizophrenia.[94] After his son's tragic death, Govig dedicated the rest of his life as an educator to pastors. In this book Govig offers several Biblical metaphors for pastoral advocacy. They include listener, mediator, and advocate. His ministry is comparable to mine in that I have three similar educational goals for my CPE program:

1. That all CPE students have a direct experience of people struggling with mental illness and addiction and they do so in a pastoral role, often as a supportive listener;
2. That all CPE students finish CPE with a broader base of pastoral skills available to minister to people struggling with mental illness and addiction;

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[93] Richard Dayringer, *Dealing with Depression: Five Pastoral Interventions* (Binghamton, NY: Haworth Press, 1995).

[94] Stewart D. Govig, *In the Shadow of our Steeples: Pastoral Presence for Families Coping with Mental Illness* (Binghamton, NY: Haworth Press, 1999).

3. That all CPE students, through this experience of ministry and learning, commit to become advocates for people with mental illness and addiction in their churches.

I am aware of only one model of comparative ministry in the broader arena of behavioral healthcare. That is the "client-directed and outcome-informed" therapy of Scott D. Miller at the Institute for the Study of Therapeutic Change in Chicago, Illinois.[95] Miller lectured at Penn Foundation last year and his client-centered model of therapy strongly parallels CPE's model of student-centered learning. Because of his conference at Penn Foundation, many of our therapists now use Miller's "Client Satisfaction Rating Scale" in their practice. With his permission, I adapted Miller's rating scale as a tool in my demonstration project. I call my paper and pencil survey a Competency Rating Scale. This survey, which is in appendix D, measures a student's perceived level of competency at various points in their CPE learning.

On the research dissertation side, Dwight D. Ham's Doctor of Ministry dissertation on learning satisfaction offers "Questions for Personal Edification" at the end of each chapter.[96] Since my demonstration project explores student satisfaction with learning, I reviewed his questions to see if they would be a helpful theological framework to incorporate into my CPE student verbatim analysis. Ham's work explores the Biblical foundations of pastoral contentment with only a cursory nod toward the behavioral sciences, although his study helped me formulate five questions I will add to our CPE Student Handbook revision in August 2007. They are:

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[95] Barry L. Duncan, Scott D. Miller, and Jacqueline A. Sparks, *The Heroic Client* (San Francisco: John Wiley & Sons, 2004), 10-12.

[96] Dwight D. Ham, "A Biblical Perspective on Learning Contentment, an Issue of the Heart" (D.Min. diss., The Master's College, 2005), 20 et passim.

1. How satisfied or dissatisfied are you with your pastoral care in this situation?
2. How does this satisfaction or dissatisfaction inform your pastoral plan for this patient/client/resident?
3. How satisfied or dissatisfied was the patient/client/resident with your pastoral care?
4. How did you asses this satisfaction or dissatisfaction?
5. What was the "gift" for you in this pastoral encounter?

CHAPTER 11

TRANSFORMATIONAL ASPECTS

It is my understanding that Pre-Modern thought begins with dogmas and doctrines (objective truth), Modern thought begins with contexts of interpretation (subjective truth), and Postmodern thought begins with negotiation (relational truth). As a Postmodern educator, negotiation is at the heart of how I supervise my CPE students. In CPE this negotiation is called "contractual learning," a term that implies co-investigation. In bell hook's book, *Teaching to Transgress*, negotiation is called "engaged pedagogy," a term she borrowed from her mentor Paulo Freire.[97]

As noted in Chapter 8, the goal of all education as the assimilation of new experience into one's life. This process of assimilation is really a process of personal integration or "personal knowledge," to use Michael Polanyi's term – a way of organizing experience by giving meaning to it. Not until some experience, idea, or person is made meaningful in terms of a cognitive, affective, or behavioral context, can it be understood by us in a personal way. Or put differently, if something were totally meaningless to us, we would not, we could not, see it. "Education would not be necessary if things were as they seem," Parker Palmer wrote.[98] Education is a profoundly personal

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[97] hooks, 20.

[98] Parker Palmer, *To Know as We are Known: Education as a Spiritual Journey* (San Francisco: Harper Row, 1982), 19.

activity which deliberately attends to our common need to know and to the future possibility that knowing holds for the individual and the wider community. This *future possibility* is the transformative quality of education. This transformative possibility is what makes CPE unique as an educational methodology for both student and supervisor.

As a pastoral educator, I was educated in what I call a pathology-based method of assessment. This method reflected an earlier method of educating therapists originally proposed by Rudolph Ekstein and Robert Wallerstein in the 1960's.[99] As medical educators, Ekstein and Wallerstein based their educational assessment and methodology on a traditional medical model, which can be summed up in two key words: *diagnose* and *treat*. In the education of therapists what was diagnosed were the problems or barriers to learning. In this model, what was not attended to were the unique gifts of the therapists-in-training. This demonstration project intentionally set aside that model of pastoral education and worked from an educational model based on gift discernment, competencies, and satisfactions or dissatisfaction with learning. By building on competencies and satisfactions and developing interventions to address dissatisfactions, I hoped to increase the CPE student's capacity for learning what it means to be a minister, with all of the transformational possibilities inherent in that learning. During the mid-unit Exit Interview I understood that the language of *gift* and *gift discernment* had not yet been fully appropriated by my students. Although I am aware of using that language and methodology in my supervision, it was not mentioned by my students during this interview. Perhaps it is still too early for them to find new words to describe their new educational experience.

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[99] Rudolph Ekstein and Robert Wallerstein, *The Teaching and Learning of Psychotherapy* (New York: International Universities Press, 1972).

My choice to shift my supervisory style to one of gift discernment does not imply that my CPE colleagues who only work from a pathology-based model of education are not effective educators. Nor do I mean to imply that they do not rely on evidence. What I tried to do in this demonstration project was to explore whether there was any legitimate evidence for my clinical decision to work from an intentionally different model.

As an educator, I believe that the assimilation of new experience into one's life need not be a solitary exercise. bell hooks understands this reality too. She writes that the "authentic self means that all who are involved help each other mutually, growing together in the common effort to understand the reality they seek to transform. Only through such praxis – in which those who help and those who are being helped help each other simultaneously – can the act of helping become free from the distortion in which the helper dominates the helped."[100] hook's transformational model of education is close to the educational model of CPE, as it moves the educational process from a hierarchical model to one of mutuality, the educational experience from one of domination to one of peership, and the educator from one of benefactor to one of partner. Put more succinctly, real education is about transformation, not information. My demonstration project created the possibility for this transformation in my students, in my curriculum development, and within myself.

Transformation implies validation. Validation is a process by which we come to appreciate and use the wider context of our growth as a meaningful instrument for interpreting our experience of self, others, and God - a way to test and generalize, and thus *integrate* the experience into a meaningful reconstruction of self. As a pastoral

[100] hooks, 54.

theologian and theological educator, the theology of Karl Rahner served as a helpful framework for me to understand our capacity and desire for engagement, validation, and transformation In Rahner's view, "people are, as questioning spirits, not in full control of their lives. They are, rather, disquieted by the way the possibilities of being remain open to something they find to be ineffable. In effect, they sense in themselves an openness to the holy mystery from whom they are to receive life as grace."[101] Rahner's theology reflects what St. Irenaeus wrote long ago - that God shared in our humanity in order that we could share in God's divinity.[102] In our sacred scriptures this sharing is metaphorically called a conversation between God and God's creatures. It is expressed with great sensitivity in both the creation and incarnation narratives, which I explored in Chapter 7. Rahner's says that this divine sharing is ontologically an "existential orientation that yearns for its fulfillment in the immediate self-communication of God."[103] This human yearning for divine fulfillment is at the heart of my transformation theology.

Engagement with the divine through "the living human documents" we meet and serve in CPE, whether they are patients or students, expands hook's notion of *engaged pedagogy* into a radically new sphere. Not by nature different from my CPE students, I am both *seeker* and *hearer* with them, and as such, their co-investigator and collaborator in real time and space. However, in order for this transformation to happen, we all need to think critically.

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[101] Kelly, ed., 36.

[102] Albert Poncelet, "St Irenaeus." *Catholic Encyclopedia* [on-line], accessed 1 August 2006, available from http:www.catholicencyclopedia.com.

[103] Kelly, ed., 320.

"It is crucial that critical thinkers who want to change our teaching practice," hooks writes, "talk to one another, collaborate in a discussion that crosses boundaries and creates a space for intervention."[104] Parker Palmer says something similar when he writes, "real learning does not happen until students are brought into relationship with the teacher, with each other, and with the subject."[105] The relationship that hooks and Palmer refer to is already structured into CPE methodology when a student presents a verbatim to her peers and supervisor or when that same student debriefs after a particularly tough overnight on-call. In this experience of co-investigation and mutuality emerges the possibility for an *engaged pedagogy* and *transformation*, as learning becomes available to *all* participants, including the CPE supervisor. An example of this mutuality is what I learned from the Exit Interview, where some of my students voiced concern that I can sometimes let them "off the hook" by providing my own solution to their learning impasses or dilemmas. This demonstration project has helped me to be more vigilant about this possibility, which I suspect may be a by-product of paying too much attention to my students' gifts.

In conclusion, I believe that it is our capacity and desire to be critical thinkers that moves us to engagement with others. By its very nature, critical thinking engages us with others. hooks calls such critical engagement "the primary element" necessary for the very possibility of change and transformation.[106] In CPE we call this change *self-awareness*, for without this capacity and desire to think critically, none of us would be able to change or grow. It is here that the educational methodology of hooks, Polanyi, and Palmer

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[104] hooks, 129.

[105] Palmer, xvi.

[106] hooks, 202.

intersect by offering student and teacher, CPE student and CPE supervisor, the possibility of an engaged pedagogy that builds on capacity, is measured in demonstrated outcomes, and holds within the experience the possibility of transformation.

APPENDICES

Power Point Presentation 1: "Gift discernment, competency, and contentment with learning" (for CPE students);

Power Point Presentation 2: "Evidence-based medicine: History and impact on behavioral medicine" (for Penn Foundation clinicians);

Power Point Presentation 3: "Outcome-based education: Can you measure pastoral learning" (for ACPE supervisors);

Power Point Presentation 4: "The Challenges of evidence-based medicine and outcome-based CPE: How CPE supervisors can help" (for ACPE supervisors).

APPENDIX A

ACPE STANDARD 311[107]

OUTCOMES OF CPE LEVEL 1 CPE

At the conclusion of Level I CPE, the student will be able to:

1. Articulate central themes of his/her religious heritage and the theological understanding that informs one's ministry;
2. Identify and discuss major life events and relationships that impact on personal identity as expressed in pastoral functioning;
3. Demonstrate the ability to initiate helping relationships;
4. Initiate peer group and supervisory consultation and receive critique about one's ministry practice;
5. Risk offering appropriate and timely critique;
6. Utilize the clinical method of learning to achieve his/her learning goals;
7. Demonstrate the ability to integrate in pastoral practice the conceptual understandings presented in the curriculum;
8. Formulate clear and specific goals for continuing pastoral formation with reference to one's strengths an weaknesses;
9. Recognize relational dynamics within group contexts.

[107] http://www.acpe.edu/acroread/2005_standards_manual.pdf, 16-17. (accessed 13 February, 2007).

APPENDIX B

ACPE STANDARD 312[108]

OUTCOMES OF CPE LEVEL 2

At the conclusion of Level II CPE, the student will be able to:

1. Articulate an understanding of the pastoral role that is congruent with his/her values, basic assumptions, and personhood;
2. Provide pastoral ministry to a variety of people, taking into consideration multiple elements of cultural and ethnic diversity, social conditions, systems, and justice issues without imposing one's own perspectives;
3. Demonstrate a range of pastoral skills, including listening/attending, empathic reflection, conflict resolution/confrontation, crisis management, and appropriate use of religious/spiritual resources;
4. Assess the strengths and needs of those served, based on an understanding of behavioral science and grounded in theology;
5. Manage ministry and administrative function in terms of accountability, productivity, self-direction, and clear, accurate clinical communication;
6. Demonstrate competent use of self in ministry and administrative function including: emotional availability, appropriate self-disclosure, positive use of
7. power, a non-anxious and non-judgmental presence, and clear and responsible boundaries;

[108] http://www.acpe.edu/acroread/2005_standards_manual.pdf, 17-18. (accessed 13 February, 2007).

8. Establish collaboration and dialog with peers, authorities and other professionals;
9. Demonstrate self-supervision through a realistic assessment of one's pastoral functioning.

APPENDIX C

PENN FOUNDATION
P. O. Box 32
Sellersville, PA 18960-0032

INFORMED CONSENT AGREEMENT

Title of Research: The Challenges of Combining Evidence-Based Behavioral Healthcare and Outcome-Based Clinical Pastoral Education

Investigator: Carl R. Yusavitz

Before agreeing to participate in this research study, it is important that you read the following explanation of this study. This statement describes the purpose, procedures, benefits, risks, and discomforts of the program.

Explanation of Procedures
You are being asked to participate in a doctoral research project to investigate the shifts and challenges of combining outcome-based behavioral healthcare and clinical pastoral education.

The approach of the research is through the use of three surveys, the supervisory process, and a didactic presentation. The surveys will include a ranking of the students own level of competency. Supervision and didactic presentation will focus upon gift discernment, competency, and contentment with learning.

Risks and Discomforts
There are no risks anticipated from your participation in this study. Potential discomforts include emotional feelings when asked questions concerning your self evaluation of strengths and weaknesses you bring to ministry.

Benefits
There are no direct benefits by participating in this research project. However, this research is expected to yield knowledge which contributes to the field of clinical pastoral education.

Confidentiality
All information gathered from the study will remain confidential. Your identity as a participant will not be disclosed to any unauthorized persons; only the researcher, Penn Foundation Advisory Site Team, and the New York Theological Seminary Research Advisor will have access to the research materials which will be kept in a locked drawer

and destroyed at the completion of the Doctor of Ministry program. Any references to your identity that would compromise your anonymity will be removed or disguised prior to the preparation of the research reports and publications.

Withdrawal Without Prejudice
Participation in this study is voluntary; refusal to participate will involve no penalty.

Questions
Any questions concerning this research project may be directed to Carl R. Yusavitz at 215-257-6551, x231.

Agreement
This agreement states that you have reviewed a copy of this informed consent. Your signature below indicates that you agree to participate in this study.

_____ _____
Signature of CPE Student Date

_____
CPE Student Name (printed)

_____ _____
Signature of Researcher, Carl R. Yusavitz Date

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APPENDIX D

PAPER AND PENCIL SURVEYS

Competency Rating Scale for Level 1 CPE Student

1 = I am not competent in this area at all

2 = I am only marginally competent here

3 = I am somewhat competent here, but I still need more experience

4 = I am competent in this area, but I still need more experience

5 = I am fully competent here

- I can clearly articulate the central themes of my religious heritage and the theological understanding that informs my ministry _____
- I can identify and discuss major life events and relationships that impact on my personal identity as expressed in my pastoral functioning _____
- I can easily initiate helping relationships _____
- I can initiate peer group and supervisory consultation and receive critique about my ministry practice _____
- I risk offering appropriate and timely critique to others _____
- I know how to utilize the clinical method of learning to achieve my learning goals _____
- I can integrate into my pastoral practice the conceptual understandings presented in the CPE curriculum _____

- ❖ I have clear and specific goals for continuing pastoral formation with reference to my strengths an weaknesses _____
- ❖ I can recognize relational dynamics within group contexts _____

Competency Rating Scale for Level 2 CPE Student

1 = I am not competent in this area at all

2 = I am only marginally competent here

3 = I am somewhat competent here, but I still need more experience

4 = I am competent in this area, but I still need more experience

5 = I am fully competent here

- ❖ I can articulate an understanding of my pastoral role that is congruent with my values, basic assumptions, and personhood _____
- ❖ I can provide pastoral ministry to a variety of people, taking into consideration multiple elements of cultural and ethnic diversity, social conditions, systems, and justice issues without imposing my own perspectives _____
- ❖ I can demonstrate a range of pastoral skills, including listening/attending, empathic reflection, conflict resolution/confrontation, crisis management, and appropriate use of religious/spiritual resources _____
- ❖ I can assess the strengths and needs of those served, based on an understanding of behavioral science and grounded in theology _____

- I can manage ministry and administrative function in terms of accountability, productivity, self-direction, and clear, accurate clinical communication

  _____

- I can demonstrate a competent use of self in ministry and administrative function including: emotional availability, appropriate self-disclosure, positive use of power, a non-anxious and non-judgmental presence, and clear and responsible boundaries _ _____
- I can establish collaboration and dialog with peers, authorities and other professionals _____
- I can demonstrate self-supervision through a realistic assessment of my pastoral functioning _____

APPENDIX E

MID-UNIT STAFF EVALUATION

Each CPE student is asked to give this mini-evaluation form to clinicians s/he has worked with during their CPE program. Your feedback is important for the CPE student to assess his/her pastoral effectiveness in a multidisciplinary setting. Please give this completed form back to your CPE chaplain intern or send it via inter-departmental mail it to Chaplain Carl Yusavitz, Penn Foundation, P.O. Box 32, Sellersville, PA 18960 by December 15, 2006. Thank you.

CPE student's name: _____

Clinical site: _____

Your position: _____

1. The CPE student's demonstrated strengths (gifts) are:
2. The CPE student's demonstrated weaknesses (growth edges) are:
3. The CPE student's major contribution to your program has been:
4. Comment on your CPE student's demonstrated capacity to work as a peer with other staff.
5. Comment on your CPE student's demonstrated maturity and judgment, especially during crisis or times of stress.
6. What is the one thing you will remember about your CPE student?
7. What advice would you offer a future CPE student in your program?
8. Any other observations?

APPENDIX F

THE EXIT INTERVIEW

PENN FOUNDATION
DEPARTMENT OF PASTORAL SERVICES
CLINICAL PASTORAL EDUCATION

THE EXIT INTERVIEW

As part of our quality improvement, an exit interview is conducted at the end of every CPE Program. However, because of the CPE research project, this Exit Interview will be conducted at the mid point of the program, December 19, 2006. A member or members of the Pastoral Services Consultation Committee (PSCC) and Site Team will conduct the interview. The interview serves four purposes:

1. Provide students with an opportunity to discuss their CPE experience and training at Penn Foundation with persons who work to shape and improve that training;
2. Provide committee members and others a glimpse into the experience of CPE students;
3. Make recommendations based on the feedback of our CPE students;
4. Provide the supervisor with consultation around themes noted, programmatic changes, or problems with learning.

Interview Outline

Initiate conversation about the CPE program. This conversation should include, but is not limited to, the following:

- Personal and professional growth for ministry
- Understanding of mental illness, addiction, recovery, sickness, and aging
- Understanding of appropriate pastoral strategies to respond to people in crisis
- Experience of peer group interaction and learning
- Integration into Penn Foundation and other healthcare communities
- Supervisory leadership
- Quality and number of didactic seminars
- Gifts they bring to ministry because of CPE
- Gifts they received from CPE
- Other concerns or recommendations

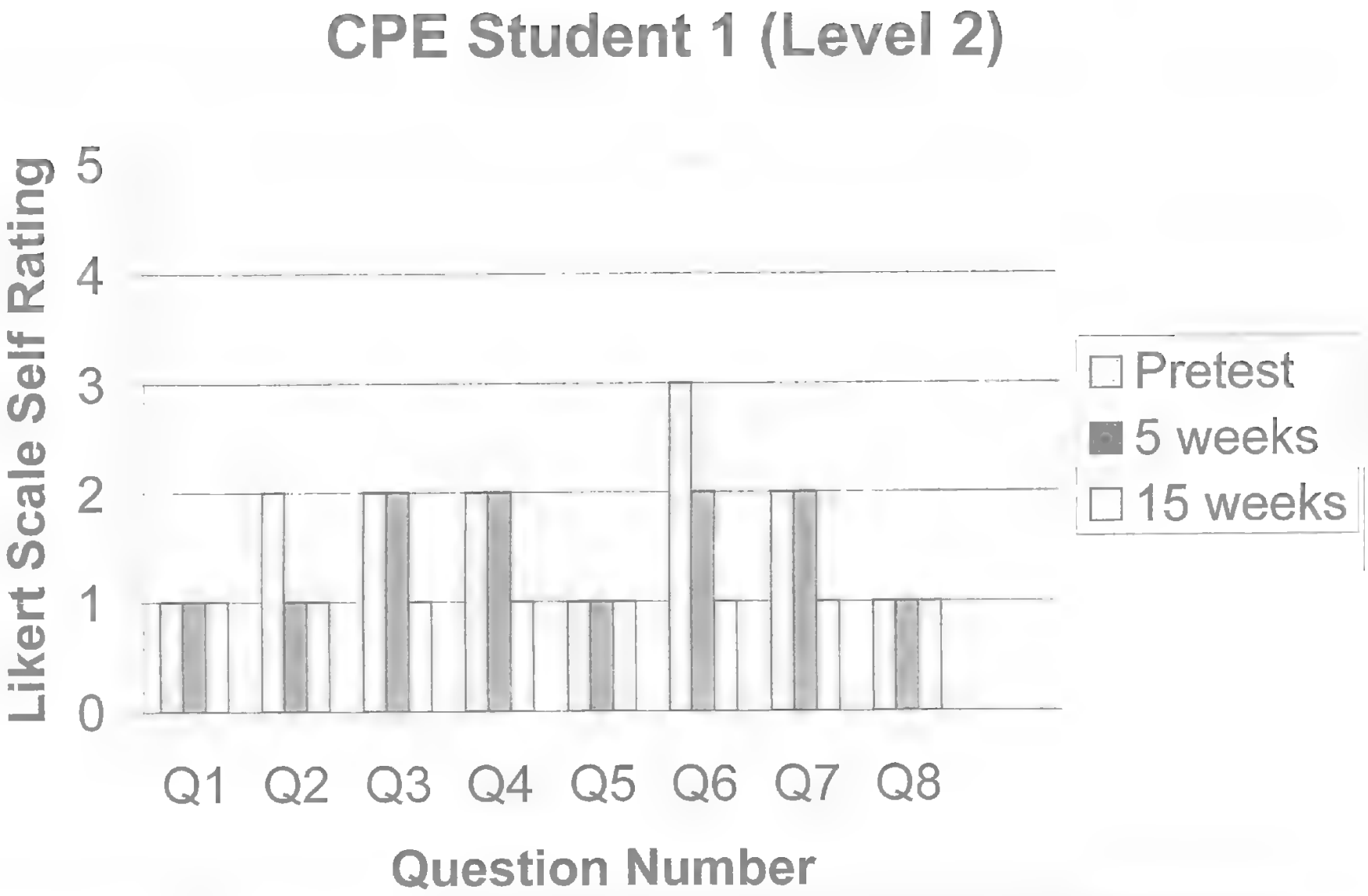
Please return the summary report to Carl Yusavitz via U.S. Post or, preferably, Penn Foundation interdepartmental mail. At our next meeting, the PSCC will review this report and recommendations.

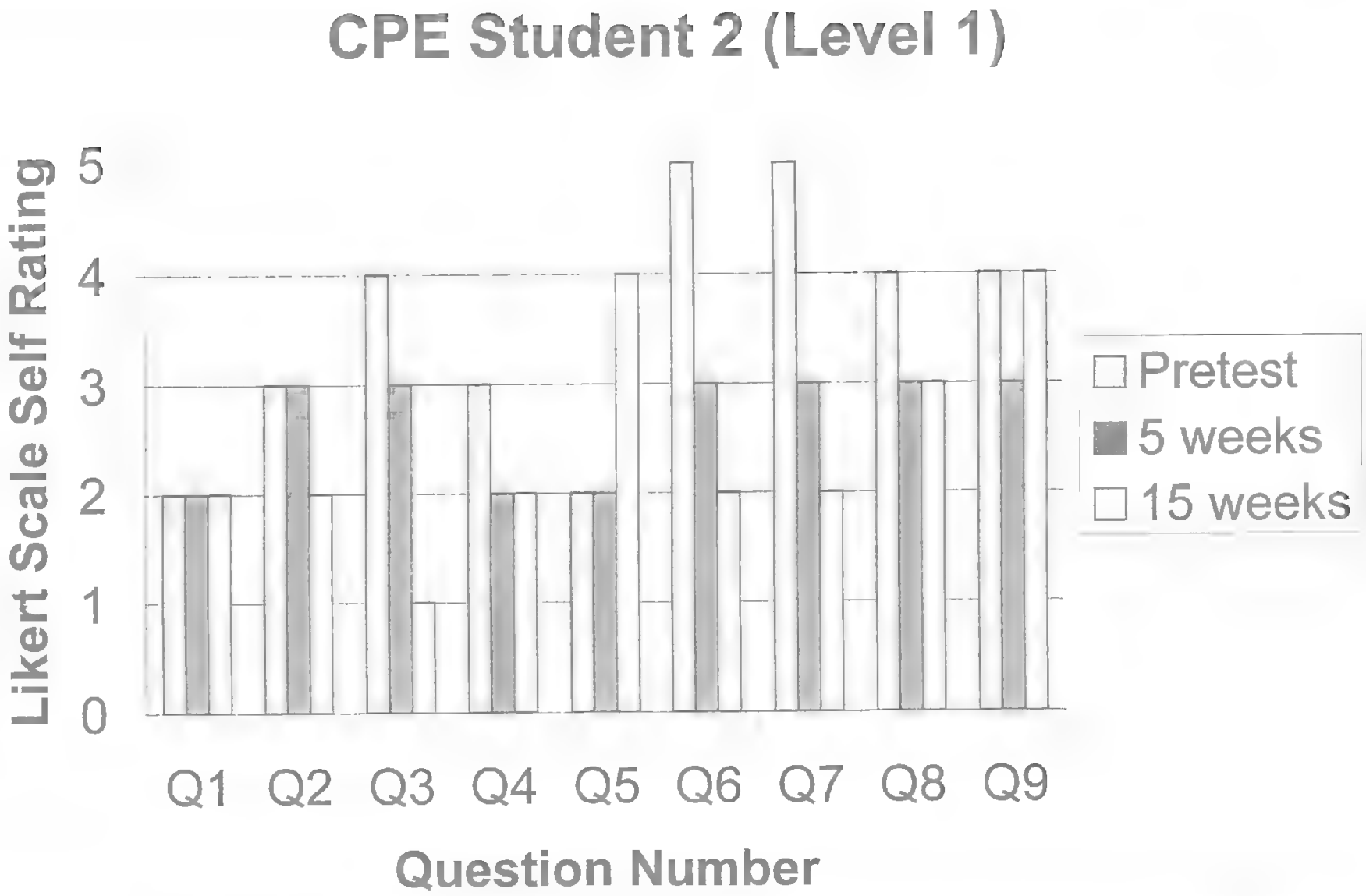
APPENDIX G

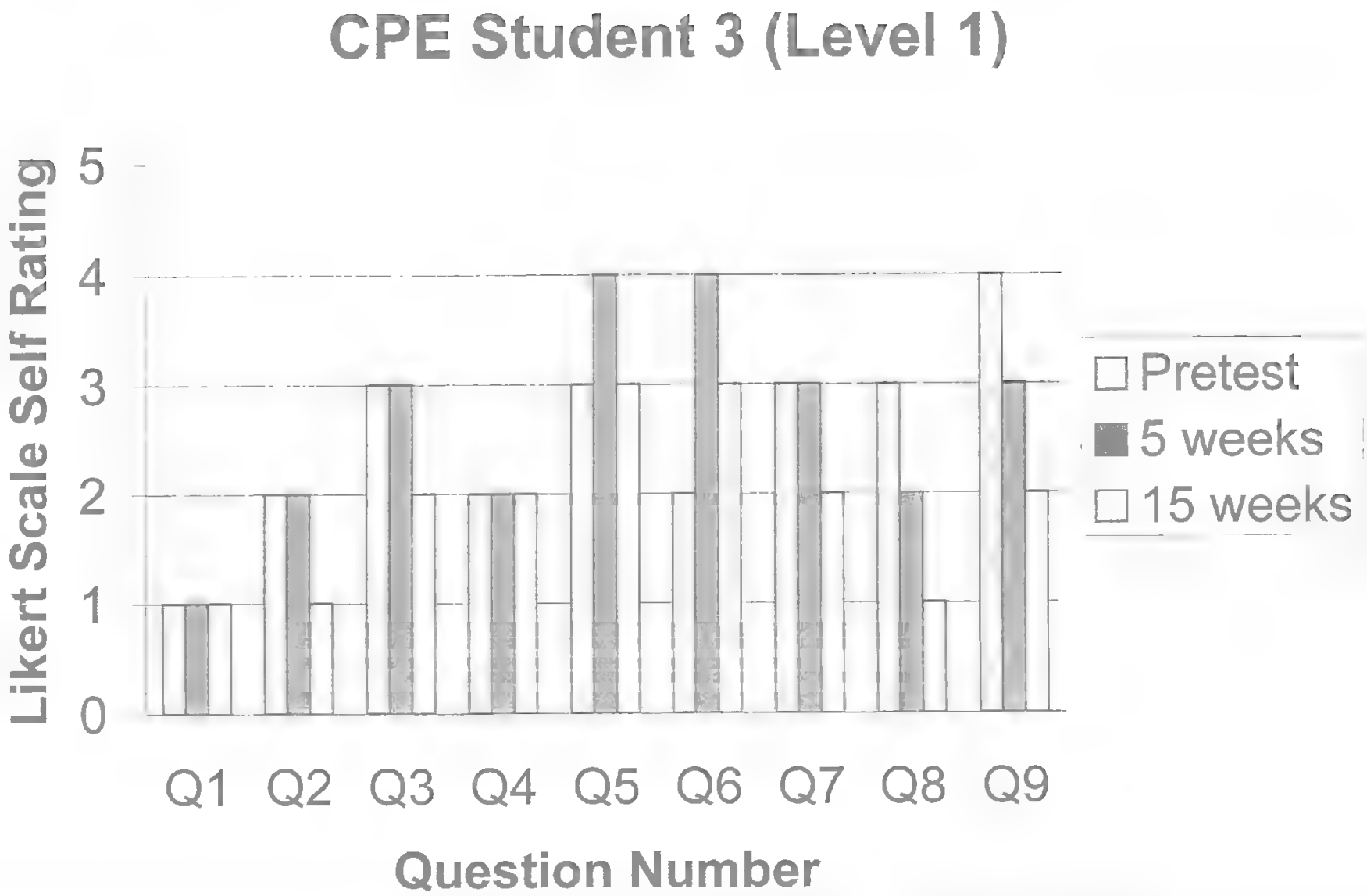
CPE Exit Interview Report
December 19, 2006

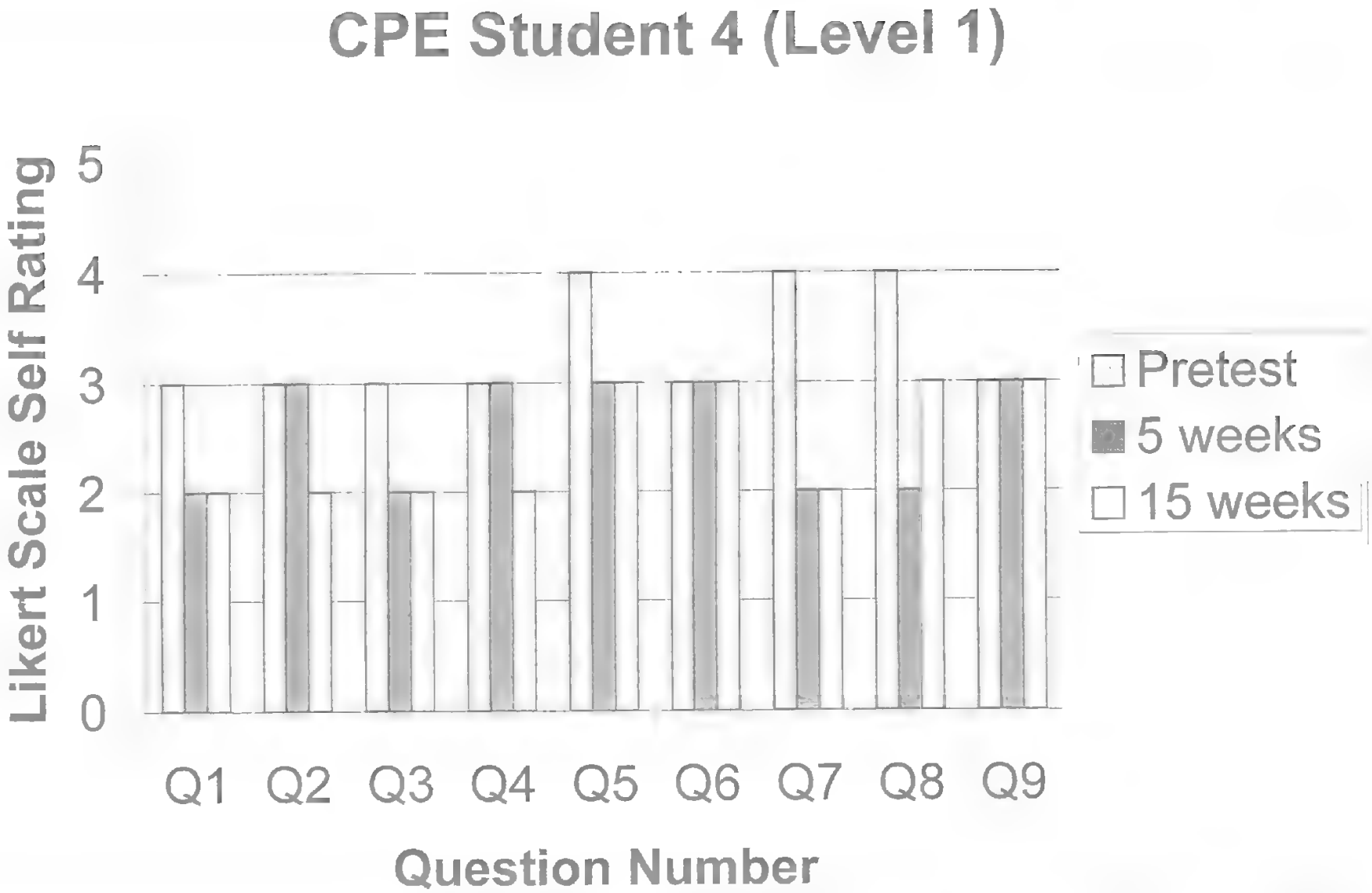
1. This group of students was deeply appreciative of the experience in CPE so far. Phrases like "it doesn't get any better than this' were scattered throughout the interview. The opportunity to learn from the other student was identified as a positive thing. One of the students said "it's like having six teachers." The privilege of learning with others deepened their experience.
2. The students recognized that their understanding of mental illness, addiction and etc. is just beginning. For most this was their first close contact with mental illness and addiction. But they have definitely gained a deeper understanding of suffering and expect that their compassion for people with serious mental illness and addiction has increased and will be helpful in their future ministry as they come in contact with troubled people. The lectures from Penn Foundation staff on the various aspects of mental illness and addiction were also very helpful.
3. The verbatims opened up new understandings of how to do pastoral care. The Bible study and prayer time were helpful and appreciated. There was some comparison between this CPE experience and others the students may have had where antagonism and conflict among student and between student and supervisor was encouraged. This has not been their experience here at Penn Foundation and the students were glad about that. They felt that the more collegial and respectful peer interactions assisted their learning in a positive way. There were expressions of appreciation for the level of intimacy that has developed among the students and the "constructive criticism" the students have given and received from each other.
4. The students were very complimentary of the supervisor leadership provided by Carl. Words and phrases like..."many strengths, responsive, gives helpful resources, provides good and helpful feedback, insightful, encouraging, psychologically bright, natural teacher"...were used. It seemed obvious that the students were genuinely appreciative and grateful for their supervision. However, some students felt that at times Carl seems to lets students "off the hook" too easily by giving solutions rather than letting the students find the solution.
5. The quality and number of didactic sessions was about right. The sessions were timely and well done. They liked "Soup Talk" presentations, but some felt that even more interaction with the "community" would be good. Others thought that the "Soup Talks" balanced lecture and discussion in a nice way.
6. This group of students liked being together and expressed several times their gratitude for the opportunity of learning from each other. They are unanimous in their appreciation of their supervisor and liked the supportive learning environment that has been developed by Carl.

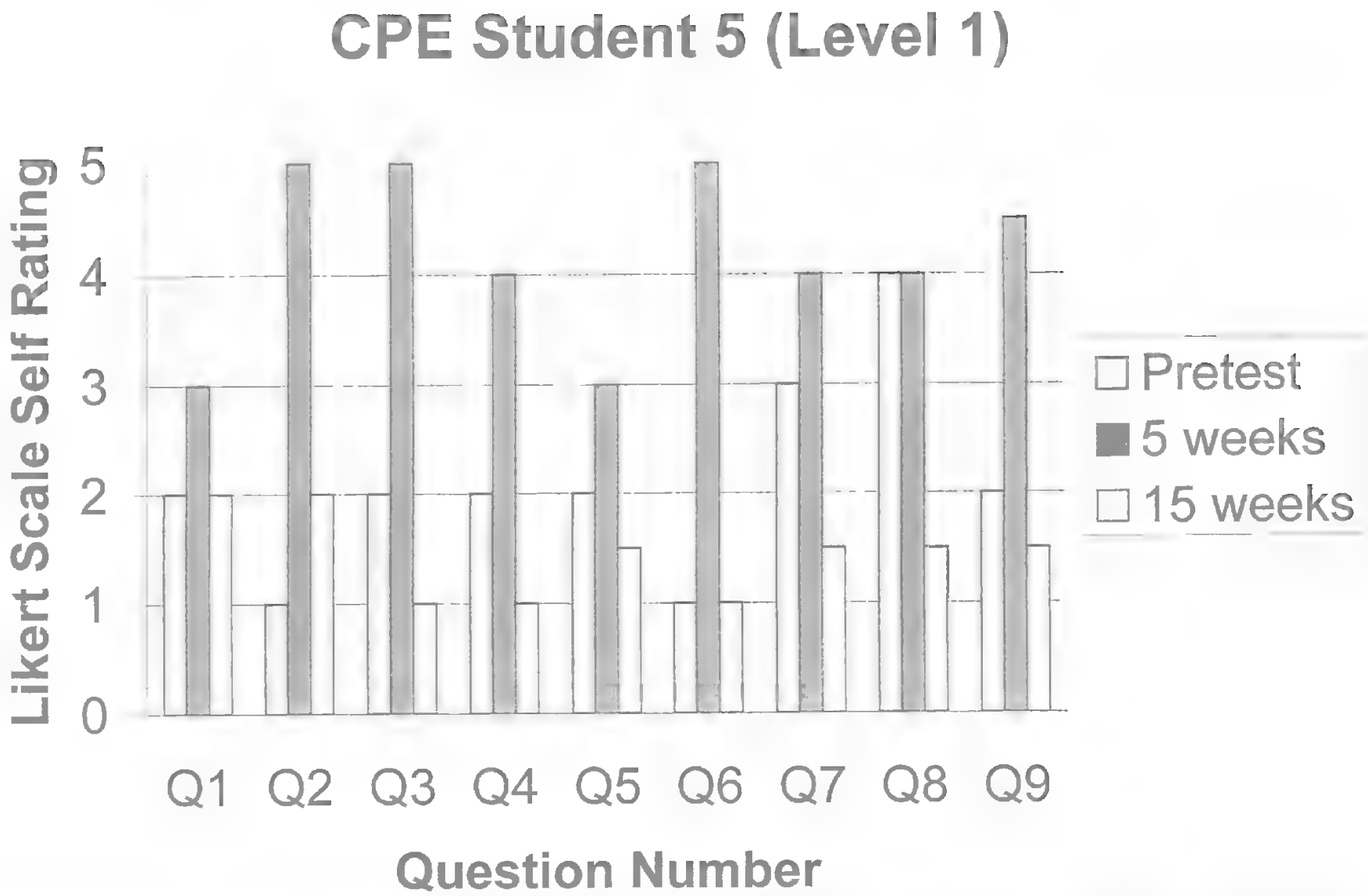
Submitted by John Goshow

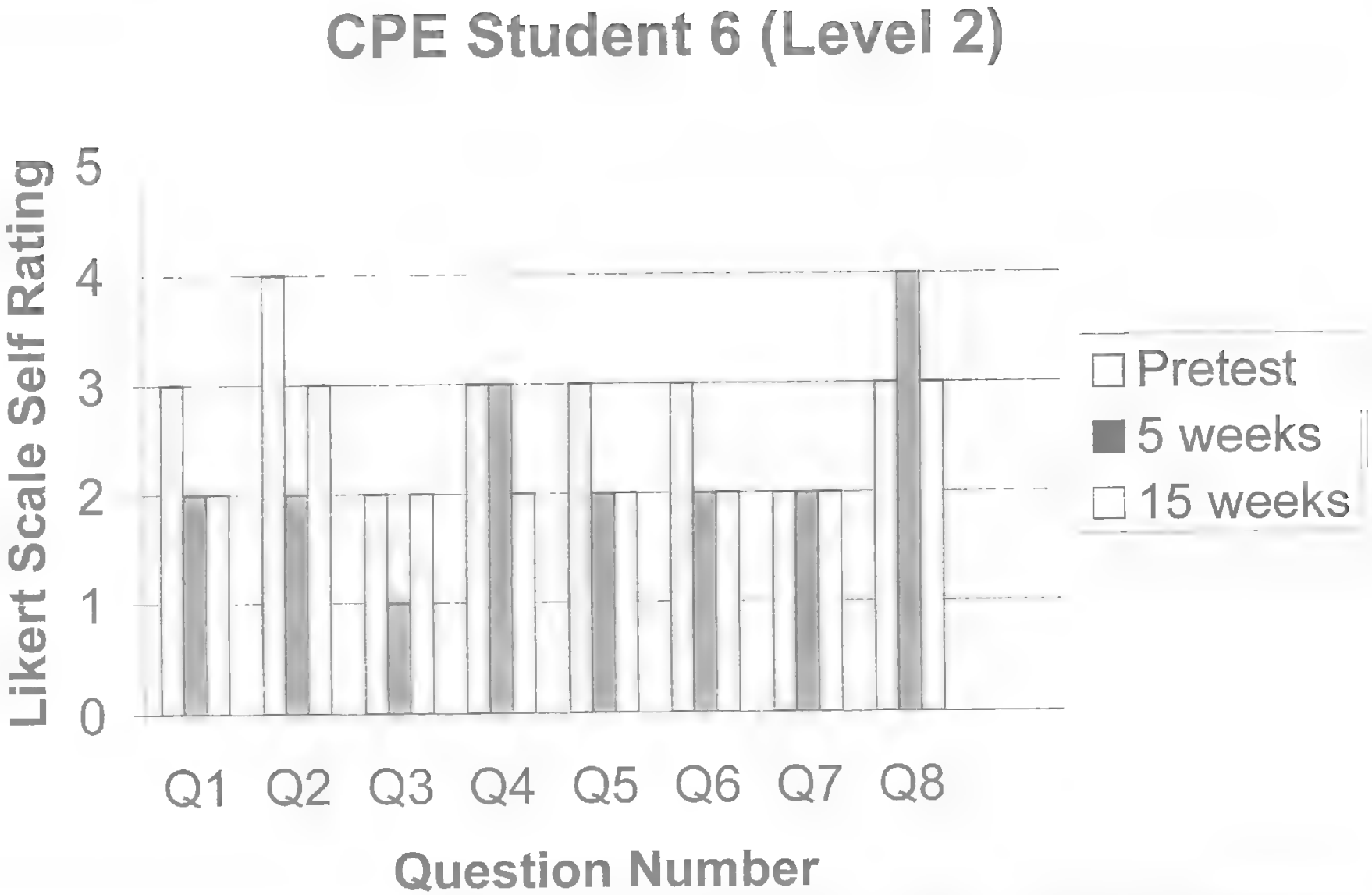

CPE Student 1 (Level 2)
Likert Scale Self Rating
5
4
3
2
1
0
Q1
Q2
Q3
Q4
Q5
Q6
Q7
Q8
Question Number
Pretest
5 weeks
15 weeks


CPE Student 2 (Level 1)
Likert Scale Self Rating
0
1
2
3
4
5
Q1
Q2
Q3
Q4
Q5
Q6
Q7
Q8
Q9
Question Number
Pretest
5 weeks
15 weeks


CPE Student 3 (Level 1)
Likert Scale Self Rating
5
4
3
2
1
0
Q1
Q2
Q3
Q4
Q5
Q6
Q7
Q8
Q9
Question Number
Pretest
5 weeks
15 weeks


CPE Student 4 (Level 1)
Likert Scale Self Rating
0
1
2
3
4
5
Q1
Q2
Q3
Q4
Q5
Q6
Q7
Q8
Q9
Question Number
Pretest
5 weeks
15 weeks


CPE Student 5 (Level 1)
Likert Scale Self Rating
0
1
2
3
4
5
Q1
Q2
Q3
Q4
Q5
Q6
Q7
Q8
Q9
Question Number
Pretest
5 weeks
15 weeks


CPE Student 6 (Level 2)
Likert Scale Self Rating
5
4
3
2
1
0
Q1
Q2
Q3
Q4
Q5
Q6
Q7
Q8
Question Number
Pretest
5 weeks
15 weeks

PENN FOUNDATION - CPE Training Program

Screen: Pastoral Care Competency Assessment

Date: - 9/1/06 - 12/31/06

Signature: Carl Yusavitz

Site Name: Penn Foundation

	Subject #					
MEASURES - Incremental change from	Student 1	Student 2	Student 3	Student 4	Student 5	Student 6
Articulate pastoral role	0	0	0	-1	0	0
Culturally competent ministry	-1	-1	-1	-1	1	-1
Demonstrate range of pastoral skills	-1	[illegible]	-1	-1	-1	0
Assess strengths and needs	-1	-1	0	-1	-1	-1
Administrative functioning	0	2	0	-1	-0.5	0
Use of self in ministry	[illegible]	[illegible]	1	0	0	-1
Collaboration and dialog with peers	-1	[illegible]	-1	-2	-1.5	0
Realistic self assessment	0	-1	-2	-1	-2.5	0
Recognize relational dynamics of groups	n/a	0	-2	0	-0.5	n/a
THRESHOLD = Gain of +1 level						

Analysis: The six CPE students reported a decrease in competency levels at the 15 week mark overall.

APPENDIX J

PLAN OF IMPLIMENTATION

Goal 1: Identify early indicators of students' competencies to determine if they are reliable predictors of future CPE outcomes

My Strategies to accomplish this goal included designing a research survey instrument based on the ACPE outcomes for Level 1 and Level 2 CPE, receiving all six CPE students' permission to participate in this demonstration project, and administering this research survey instrument to all students before CPE, during the 3rd week of CPE, and during the 15th week of CPE.

Outcomes included the design of the research instrument prior to September 5, 2006, signed agreement by all students participate in this demonstration project during the CPE orientation, and the administration of the research survey instrument before CPE, during the 3rd week of CPE, and during the 15th week of CPE.

The competency rating scales, found in appendix D, were my demonstration project's primary research tool to measure CPE students' perceived learning over fifteen weeks. The self-assessment graphs, found in appendixes H and I, charted this learning. The graphs do not indicate a smooth learning curve from levels of incompetence to competence. Rather, they indicate that student self-assessment of their competencies was generally high *before* CPE and then fluctuated dramatically *during* CPE. Initially I saw this outcome as antithetical to my goal. However, as I reflected on the graphs, I realized two important things. One, a drop in perceived competency by the fifteenth week may indicate a more realistic self-assessment of one's competency based on the ACPE

outcomes – something I explored in Chapter 9. Secondly, in consultation with my D. Min. Site Team, I came to the realize that fifteen weeks may not be enough time to identify early indicators of students' competencies to determine if they are reliable predictors of future CPE outcomes.

Goal 2: Identify whether an intentional focus on CPE students' gifts and strengths reliably predicts future learning outcomes

My strategies to accomplish this goal included teaching a didactic to all CPE students on an educational methodology based on gift discernment, competency, and contentment with learning and developing a strong supervisory alliance with each student in individual supervision.

Outcomes included participation by all students in the didactic presentation on September 12, 2006 and careful monitoring of the supervisory alliance with supervisory process notes. These process notes were kept in a locked file cabinet. A summary of these process notes was shared with my D. Min. Site Team on January 2, 2007.

My primary tools to measure this goal were my supervisory notations, the mid-unit staff evaluations and the exit interview. My supervisory notations indicated overall student satisfaction with their CPE learning. My students' staff evaluations all mentioned individual gifts for ministry, which I shared with my students in supervision. The exit interview report, however, mentions no "gift" or "gift discernment" language. Consequently, the outcomes of an intentional focus on CPE students' gifts and strengths as reliable predictors of future learning are mixed.

Goal 3: Explore and compare the paradigmatic shifts and challenges in moving from pathology-based behavioral medicine and clinical pastoral education to outcome-based medicine and education

My strategies to accomplish this goal included meetings with Penn Foundation's CEO, Director of Mental Health Services, and a our research psychiatrist, as well as a thorough exploration into ACPE's history and relationship with the United States Department of Education. These conversations and research formed the basis of four didactic presentations, found in appendix L. The target audiences of these Power Point presentations included CPE students, Penn Foundation clinicians, and ACPE supervisors.

Outcomes of my research revealed paradigmatic shifts in the teaching and practice of medicine and education in America during past generation. I highlighted the shifts and challenges involved in these shifts in Chapters 2, 3, and 8. The four Power Point presentations will be used with future CPE students as a didactic, with clinicians at Penn Foundation as an in-service training, and with ACPE supervisors as a workshop at the 2008 regional meeting.

APPENDIX K

MINISTERIAL COMPETENCIES

DESCRIPTION OF THE EVALUATION PROCESS

The site team committee met for a second time on June 14, 2006. Present at the meeting were Karen Rosenberger, John Goshow, Marianne Gilson, and Deborah Rahn-Clemens. Absent was Robert Rapkin.

Carl reviewed his revised Challenge Statement and Goal/Objectives with the group. Feedback was positive, although two things were mentioned:

- ❖ Don't get too far a-field with the history and social analysis
- ❖ Don't lose track of the theology underneath this project

The rest of the meeting was devoted to feedback from the Ministerial Competency Assessment instrument.

Overall, the site team made it clear how much they appreciated Carl's presence and behavior at Penn Foundation. Among the competencies they mentioned were:

1. Intellectual ability and capacity to draw from many resources
2. High role definition and pastoral authority
3. Theologically and biblically articulate
4. Good grasp of behavioral healthcare
5. Good communication and motivational skills
6. Educational diagnostic skills
7. Good grasp of group dynamics and process
8. Openness and transparency

9. Inclusive ministry
10. Ability to work in a multidisciplinary setting
11. High ethical and social justice awareness
12. Compassion
13. Ability to deliver constructive criticism in a gentle way
14. Good sense of humor
15. Vision
16. Reliability

Among the recommendations they mentioned were:

1. Build in times of Sabbath rest and rejuvenation
2. Pay closer attention to the prophetic component in CPE
3. Regulate his enthusiasm for ministry and education so that he talks less in group settings
4. Clarify his ecclesiastical endorsement and licensing
5. Continue his social analysis of CPE and behavioral healthcare after his NYTS project is finished
6. Work on his delegation skills
7. Initiate connections with local non-Christian faith communities
8. Work at balancing his personal pastoral presence at Penn Foundation with the programs he develops and facilitates for the community
9. Read more about conflict resolution

Robert Rapkin, absent from this meeting, promised to meet 1:1 with Carl regarding his demonstrated competencies.

SELECTION OF COMPETENCIES TO HONE

In e-mail correspondence with the Rev. Dr. Martha Jacobs, Coordinator of the New York Theological Seminary D. Min. program in pastoral supervision, and members of my Site Team during the week of June 30, 2006, I decided to hone in on two competencies which would greatly inform my D. Min. project and CPE supervision. They are recommendations "2" and "3" in the earlier section "Ministerial Competencies and Description of the Evaluation Process:"

- ❖ Pay closer attention to the prophetic component in CPE;
- ❖ Regulate his enthusiasm for ministry and education so that he talks less in group settings.

COMPETENCIES, GOALS, OBJECTIVES, STRATEGIES, AND EVALUATION CRITERIA

1. "Pay closer attention to the prophetic component in CPE"

   Objective: By October 31, 2006 I will read more about ACPE's prophetic mission and introduce a prophetic didactic in my Level 1 CPE curriculum.

   Strategies: I will identify books and articles that address this topic and revise the CPE Handbook (under the section "ACPE CPE") with a paragraph on the prophetic role of CPE in theological education.

   Evaluation Criteria: I will incorporate this prophetic component in the transformation section of my demonstration project.

2. "Regulate his enthusiasm for ministry and education so that he talks less in group settings"

Objective: Beginning in September 2006, I will be more mindful of my verbal input in groups, especially my CPE group.

Strategy: I will intentionally solicit feedback from group participants once a week and document that feedback in a supervisory journal

Evaluation Criteria: I will intentionally include an opportunity for feedback in this area on my CPE student mid-unit self-evaluation.

RESPONSES TO MINISTERIAL COMPETENCIES

1. "Pay closer attention to the prophetic component in CPE"

I re-read the Introduction of Glenn Asquith's *Vision from a Little Known Country: A Boisen Reader*, with particular interest in the contributions of Anton Boisen, Richard Cabot, and Helen Flanders Dunbar. I also read Joan Hemenway's recent article in the Journal of Pastoral Care and Counseling titled "Opening up the Circle: Next Steps in Process Group Work in Clinical Pastoral Education (CPE)." I used this learning to revise the CPE Student Handbook with a paragraph on CPE's prophetic role in the history of ministerial education. This revision will be incorporated in the September 2007 edition of the handbook. Chapter 11 of this demonstration project also reflects this learning.

2. "Regulate his enthusiasm for ministry and education so that he talks less in group settings"

I faithfully documented my participation in all weekly CPE group educational activities, with an eye on my verbal input. These are my Supervisory Notations,

mentioned below, which I submitted to my Site Team. The CPE student mid-unit self-evaluation included a section for student feedback on this subject.

SUPERVISORY NOTATIONS

Because of confidentiality, the supervisory process notes, mentioned above, are not included in this demonstration project. However, in Chapter 4 I anonymously included student satisfactions and dissatisfactions about learning and my supervisory interventions.

Gift discernment, competency, and contentment with learning

What are your Gifts for Ministry?

- Reflective listening skills
- Assessment skills
- Healthy boundaries
- Awareness of one's strengths and weaknesses
- Love of ministry
- The capacity to receive constructive criticism

What are your impressions of CPE?

- Rigorous supervision
- Honest feedback from peers
- Anticipated helplessness in the face of new experience
- A change of pastoral identity and functioning
- Personal healing
- Intimacy
- Strict confidentiality

Double-Loop Learning

- "If you tell me, I'll probably forget it. If you show me, I'll probably remember it. If you involve me, I'll learn from it."
- "Whatever answer you come up with always leads to more questions."

Richard Cabot, Anton Boisen, and Helen Flanders Dunbar

- What was Cabot's contribution to CPE?
- What was Boisen's?
- What was Flanders Dunbar's?

What does “clinical” mean in CPE?

- Let’s explore Michael Polanyi’s stages of awareness: paying attention, reflection, decision, and commitment

How does the Association of Clinical Pastoral Education define competencies?

- The outcomes of Level 1 and Level 2 CPE (handout)

How do you understand the term "gift discernment?"

- What is a gift?
- Where do gifts come from?
- How do we know we have a gift?
- What is the usefulness of gifts?

What Biblical passages or theology comes to mind when you think of the word "gift" and "gift discernment?"

- *2 Timothy 2: 7 "Mark well what I am saying: the Lord will give you discernment in all things."*
- *1 Corinthians 12, 13, 14*

- *There are varieties of gifts, but the same Spirit*
- *The Spirit bestows these gifts*
- *Love is the greatest spiritual gift*
- *Be zealous about your gifts*

How are gift discernment and learning connected?

- How do YOU learn?
- How did you learn about YOUR gifts for ministry?

Pathology-based vs. talent-based CPE

- Brief explanation of my D. Min. research project

Evidence Based Medicine

History and
Impact on Behavioral Medicine

History of EBM

- 1992 = First JAMA reference
- 1999 = Clinical epidemiologists at McMaster University in Ontario, Canada, popularize the term
- EBM's pioneer = the 19th Century physician Pierre Charles Alexandre Louis

Why was Louis' work so important?

- Cf. the culture of "academic medicine"
- Louis' thorough physical exams, careful documentation, and empirical evidence moved medicine away from academic medicine

First published in English in 1936

- Many 19th Century American physicians went to Paris to study medicine
- Louis' work causes a storm in American when published
- He comes to America to lecture
- Oliver Wendell Holmes and other American physicians take up EBM
- EBM quickly spreads to medical schools

EBM was first called "numerical medicine"

- Louis' work documented morbidity and mortality by assigning progress or decline with numbers
- Medicine became more "scientific"
- Scientific medicine became the norm in American medical practice

What is EBM?

- "…the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research." (BMJ)

What are EBM'S Implications for Behavioral Healthcare?

- Behavioral healthcare's history within the history of medicine
- Is there biomedical evidence for mental illness?
- Who pays for behavioral healthcare?

Cultural Implications

- Deinstitutionalization
- Safety nets
- Managed Care movement
- Patient autonomy movement
- Shrinking government dollars for healthcare
- Parity

Justice issues

- Scarcity of resources
- Stigmatization of people with mental illness
- Imprisonment of people with mental illness
- Advocacy

Implications for Penn Foundation

- Who holds us to our mission?
- Who holds us to our core values?
- How do you understand our future?
- What hope do you have for Penn Foundation?

Outcome-Based Education

Can you measure pastoral learning?

What is OBE?

- The demonstrated assessment of one's learning against an external goal (an "outcome") and the development of a setting and curriculum that can facilitate the achievement of that learning.
- Ralph W. Tyler's book *Basic Principles of Curriculum and Instruction* asked four simple questions:

Tyler's Questions

- What educational purpose should the school [or church or educational association like ACPE] attain?
- What educational [or pastoral] experiences are most likely to accomplish these purposes?
- How can these educational experiences be effectively organized [into objectives and outcomes]?
- How can we measure success?

ACPE History with OBE

- 1967 consolidation
- 1969 affiliation with U.S. Department of Education
- 2002 change in ACPE Standards

What does OBE add to CPE?

- A framework to understand and measure educational progress
- Identification of "best practices" in pastoral care
- The development of more uniform curricula for CPE students, supervisory education supervisors, and certification committees

What are the dangers of OBE CPE?

- Loss of creativity
- Mistrust of "process learning"
- Weakening of the individual CPE student's learning contract
- Repositioning of the supervisor as "judge" vs. "co-investigator"
- "Teaching to the test"

How effective is OBE CPE

- The evidence is still "out"
- More documentation is needed
- The dissemination of educational theories and best practices that "work" is needed

The challenges of evidence-based medicine and outcome-based CPE:

How CPE supervisors can help

EBM

- The history of EBM
- Academic medicine vs. scientific medicine
- The climate of EMB in the U.S. today
- Most CPE programs are housed in hospitals where EMB is practiced

CPE as a multidisciplinary skill

- What is your role in your hospital?
- Who designed your JD?
- Who revises it?
- What role does pastoral education play in your hospital?
- Where are you in the religion/faith/spirituality debate?

CPE Research

- Have you been involved in pastoral research?
- How have you been trained to do research?
- What interests you?

What has been your experience with the outcomes?

- How did you learn to do what you do?
- Where did you get your educational theories?

How do you understand best practices in pastoral care?

- Can we call the outcomes "best practices?"

What is the history of OBE and CPE?

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A plea for more documentation

- Necessity of pastoral research

Was Cabot right, all along?

- Boisen's contribution to CPE
- Cabot's contribution
- Flanders Dunbar's contribution

BIBLIOGRAPHY

The Association of Clinical Pastoral Education, Inc. Standards. http://www.acpe.edu/acroread/2005_standards_manual.pdf, 309-12.

"A Call for Change: Toward a Recovery-Oriented Mental Health Service System for Adults," The Pennsylvania Office of Mental Health and Substance Abuse Services 2005.

Allan, Johanna. "Learning Outcomes in Higher Education." *Studies in Higher Education* 21, no. 1 (1996): 93-108.

Altschuler, L., A. Haroun, B. Ho, and A. Weimer. "Did Samson have an antisocial personality disorder?" *Archives of General Psychiatry* 59 (2002): 565-6

Asquith ,Glenn, ed. *Vision from a Little Known Country: A Boisen Reader.* Decatur, Georgia: Journal of Pastoral Care Publications, 1992.

Bay , Paul. "Chaplaincy Research: A Case Study." *The Journal of Pastoral Care and Counseling* 60, no. 3 (2006): 343-52.

Bellah , Robert N.. "Is there a common American culture?" *Journal of the American Academy of Religion* 66, no. 3 (Autumn 1998): 613-25.

Bruner, Jerome. *Acts of Meaning*. Cambridge, Massachusetts: Harvard University Press, 1991.

Bufford, Rodger K. *Counseling and the Demonic*. Dallas, Texas: Word Publishing, 1988.

Capps, Donald. *The Pastoral Care Case: Learning about Care in Congregations*. St. Louis, Missouri: Chalice Press, 2001.

Cooper, John. "Entering the Minds of the Mentally Ill." *The Journal of Pastoral Care* 54, no. 2 (summer, 2000): 203-05.

Corrigan, Patrick and Robert Lundin. Don't Call Me Nuts! Tinley Park, Illinois: Recovery Press, 2001.

Cranton, Patricia. *Professional Development as Transformative Learning: New Perspectives for Teachers of Adults*. San Francisco: Jossey-Bass, 1996.

Dayringer, Richard. *Dealing with Depression: Five Pastoral Interventions*. Binghamton, New York: Haworth Press, 1995.

Derrick, Reg. "Justifications for learning outcomes: more appropriate educational theories," *Medical Education* 38 (2004), 1203-1205.

Detweiler, Robert and William G. Doty, eds. *The Daemonic Imagination: Biblical Text and Secular Story*. Atlanta, Georgia: Scholars Press, 1990.

Dewey, John. *Experience and Education*. New York: Macmillan,1938.

Duncan, Barry L., Scott D. Miller, and Jacqueline A. Sparks. *The Heroic Client: A Revolutionary Way to Improve Effectiveness through Client-Directed Outcome-Informed Therapy*. San Francisco: Jossey-Bass, 2004.

Eiselen, Frederick C., ed. et al. *The Abingdon Bible Commentary*. Nashville, Tennessee: Abingdon Press, 1929.

Findlay , Stephen. "Managed Behavioral Health Care in 1999: An Industry at a Crossroads." *Health Affairs* 18, no. 5 (1999): 116-124.

Gerkin, Charles W. *The Living Human Document: Re-Visioning Pastoral Care in a Hermeneutical Mode.* Nashville, Tennessee: Abingdon Press, 1984.

Gleason, John. "Evidence-based Standards of Care in Pastoral Education." *The Journal of Pastoral Care and Counseling* 60, no. 3 (2006): 195-99.

Gladwell, Malcolm. "The Moral Hazard Myth: The Bad Idea behind our Failed Health Care System." *New Yorker*, 29 August, 2005,: 1-7, available from http://www.Gladwell.com.

Govig, Stewart D. *In the Shadow of our Steeples: Pastoral Presence for Families Coping with Mental Illness*. Binghamton, New York: Haworth Press, 1999.

Guskey, Thomas R.. *Outcome-based education and mastery education: Clarifying the differences*. New Orleans: American Educational Research Association, 1994. ERIC, ED 368 770: 4.

Hall, Charles E.. *Head and Heart: The Story of the Clinical Pastoral Education Movement*. Decatur, Georgia: Journal of Pastoral Care Publications, Inc., 1992.

Ham, Dwight D. "A Biblical Perspective on Learning Contentment, an Issue of the Heart." M.A. diss., Master's College, 2005.

Handelsman, Mitchell M., Michael C. Gottleib, and Samuel Knapp. "Training Ethical Psychologists: An Acculturation Model." *Professional Psychology* 31, no. 1 (2005): 59-65. http://www.apa.org/journals/pro.html.

Hemenway, Joan E.. *Inside the Circle: A Historical and Practical Inquiry Concerning Process Groups in Clinical Pastoral Education.* Decatur, Georgia: Journal of Pastoral Care Publications, 2000.

_____. "Opening Up the Circle: Next Steps in Process Group Work in Clinical Pastoral Education (CPE)." *Journal of Pastoral Care and Counseling* (Winter 2005): 323-334.

Hilfiker, David. "When Mental Illness Blocks the Spirit." *The Other Side* (May/June 2002): 10-15.

hooks, bell. *Teaching to Transgress*. New York: Routeledge Press, 1994.

Hopkins, Elaine, Zo Woods, Russell Kelly. Katrina Bentley, and James Murphy. *Working with Groups on Spiritual Themes: Structured Exercised in Healing*, vol. 2. Duluth, Minnesota: Whole Person Associates, 1995.

Isaacs, T. Craig. "The Possessive States Disorder: The Diagnosis of Demonic Possession." *Pastoral Psychology* 35 (1987): 263-73.

Kearney, James. "Outcome-Based Education: Final Report." Moscow, Idaho: University of Idaho, ERIC Pub., no. ED 373-457: (1994).

Kegan, Robert. *The Evolving Self.* Cambridge, Massachusetts: Harvard University Press, 1982.

_____. *In Over our Heads: The Mental Demands of Modern Life.* Cambridge, Massachusetts: Harvard University Press, 1994.

Knowles, Malcolm S.. *The Modern Practice of Adult Education: from Pedagogy to Andragogy.* Chicago: Follett Publishing Co., 1980.

Longo, Daniele A. and Stephanie M. Peterson. "The Role of Spirituality in Psychosocial Rehabilitation." *Psychiatric Rehabilitation Journal* 25, no. 4 (2002): 333-40.

Lowe, C. Marshall and Roger O. Braaten. "Differences in Religious Attitudes in Mental Illness." *Journal for the Scientific Study of Religion* 5 (1966): 435-45.

Mayou, Richard. "Are psychological skills necessary in treating all physical disorders?" *Australian and New Zealand Journal of Psychiatry* 39 (September 2005): 800-808. http://www.blackwell-synergy.com.

Mowbray, Carol T., Kyle L. Glazier, and Mark Holter. "Managed Behavioral Health Care in the Public Sector: Will It Become the Third Shame of the States?" *Psychiatric Services* 53 (2002): 157-170.

The New English Bible with the Apocrypha. Oxford: Oxford University Press, 1970.

Nys, Thomas R. V. and Maurits G. Nys. "Psychiatry under pressure: Reflections on psychiatry's drift towards a reductionist biomedical conception of mental illness." *Medicine, Healthcare, and Philosophy* 9 (2006), 107-115.

Palmer, Parker. *To Know as We are Known: Education as a Spiritual Journey*. New York: Harper Collins Publishers, 1993.

Patte, Daniel, ed. *Global Bible Commentary*. Nashville, Tennessee: Abingdon Press, 2004.

Pearson, Stephen D., Franklin G. Miller, and Ezekiel J. Emanuel. "Medicare's Requirement for Research Participation as a Condition of Coverage: Is it Ethical?" *Journal of the American Medical Association* 296, no. 8 (2006): 988-991.

Pohly, Kenneth. *Transforming the Rough Places: The Ministry of Supervision*, 2nd ed. Franklin, Tennessee: Providence House Publishers, 2001.

Polanyi, Michael. *Personal knowledge: Toward a post-critical philosophy*. Chicago: University of Chicago Press, 1958.

Powell, Robert C. *Fifty Years of Learning Through Supervised Encounter With Living Human Documents*. New York: The Association of Clinical Pastoral Education Publications, 1975.

"President's New Freedom Commission on Mental Health - Achieving the Promise: Transforming Mental Health Care in America." http://www.mentalhealthcommission.gov/reports/Final Report/FullReport-03.htm.

Rangachari, P. K. "Evidence-based medicine: Old French wine with a new Canadian label?" *Journal of the Royal Society of Medicine* 90 (1997): 280-84.

Rahner, Karl. *Karl Rahner: Theologian of the Graced Search for Meaning*. Edited by Geoffrey B. Kelly. Minneapolis, Minnesota: Fortress Press, 1992.

_____. *A World of Grace: An Introduction to the Themes and Foundations of Karl Rahner's Theology*. Edited by Leo J. O'Donovan. New York: Crossroads Publishing Co., 1991.

Sackett, D. L., W. M. C. Rosenberg, J. A. M. Gray, R. B. Hayes, and W. S. Richardson. "Evidence-based medicine: what it is and what it isn't." *British Medical Journal* 312: 71-72.

Sanchez, Lisa M. and Samuel M. Turner. "Practicing psychology in the era of managed care: Implications for practice and training," Am*erican Psychologist* 58, no. 2 (2003): 116-129. http://www.apa.org/journals/amp.html.

Scheid, Teresa. "Rethinking professional prerogative: managed mental healthcare providers." *Sociology of Health and Illness* 22, no. 5 (2000): 700-19.

Scott, W. R., M. Ruef, P. Mendel, and C. A. Caroneer. *Institutional Change and Organizational Transformation of the Healthcare Field.* Chicago: University of Chicago Press, 2000.

Sedmak, Clemens. *Doing Local Theology: A Guide for Artisans of a New Humanity.* Maryknoll, New York: Orbis Press, 2002.

Segovia, Fernando and Mary Ann Tolbert, eds. *Readings from this Place,* vols. 1 and 2. Minneapolis, Minnesota: Fortress Press, 1995.

Sheehan, William and Jerome Kroll. "Psychiatric Patients' Beliefs in General Health Factors and Sin as Causes of Illness," *American Journal of Psychiatry* 147, no. 1 (1990): 112-13.

Stokes, Allison. *Ministry after Freud.* New York: The Pilgrim Press, 1985.

Swinton, John. *Resurrecting the Person: Friendship and the Care of People with Mental Health Problems.* Nashville, Tennessee: Abingdon Press, 2000.

Tanaka, Nabukazu. "Spiritual Dimensions as Factors of Client Satisfaction with Pastoral Counseling". M.A. diss., Garrett-Evangelical Theological Seminary, 1991.

Worcester, Elwood and Samuel McComb, *The Christian as a Healing Power.* New York: Moffat, Yard and Co., 1909.

Yalom, Irvin D. *The Theory and Practice of Group Psychotherapy*, 3rd ed. New York: Basic Books, 1985.